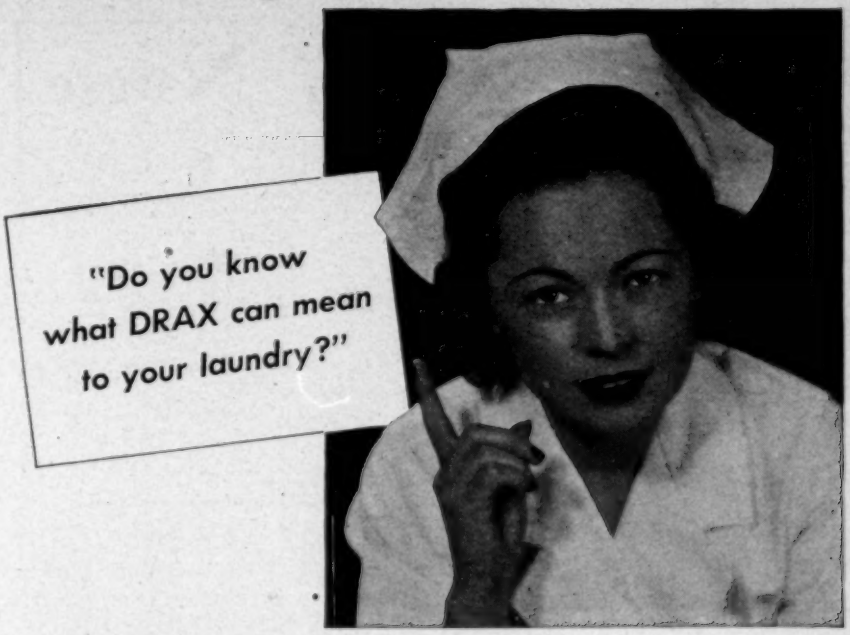

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Reader's Guide

After ten years of tethered activity, the International Council of Nurses has convened this month in Atlantic City, N.J. The general secretary of the Canadian Nurses' Association, **Gertrude M. Hall,** has been an active participant in all of the deliberations. She has promised to provide the readers of the *Journal* with a full word picture of the happenings, written in her own inimitable style. We hope that we shall be able to feature this material in an early summer issue.

The dominant note this month stresses various aspects of the maternity cycle. Adequate prenatal care is one of the products of the twentieth century. Its importance has been proven on countless occasions. Despite the establishment of clinics in out-patient departments, increased supervision by physicians, and a broader instruction by nurses, much still can be accomplished in reaching the expectant mothers early in their pregnancy. **Grantley Dick Read, M.A., M.D.,** is a leader in this field in Britain. Through the courtesy of the League of Red Cross Societies we are able to present his very logical and useful program of health education for the pregnant woman.

Gertrude Armstrong, who is supervisor of the operating and delivery rooms at the Royal Victoria Montreal Maternity Hospital, has described in detail the steps that are taken following the admission of a patient. The technique used in the labor and case rooms is a sound model that any hospital might follow. Special mention should be made of the excellent photographs by Hayden, F.R.P.S., which illustrate the set-up and equipment.

Not all deliveries occur in hospital. In northern Alberta, miles from the nearest doctor, the specially prepared district nurses conduct the confinements with skill and precision. **Beth Laycraft** has given us a detailed description of this phase of their work.

To round out this series of articles, we present an able discussion of the problems the unmarried mother faces, the decisions she has to make, and how help can be given to her. This article, by **N. W. Philpott, M.D.** and **Christina F. Goodwin,** is reprinted with the kind permission of the *Canadian Medical Association Journal.*

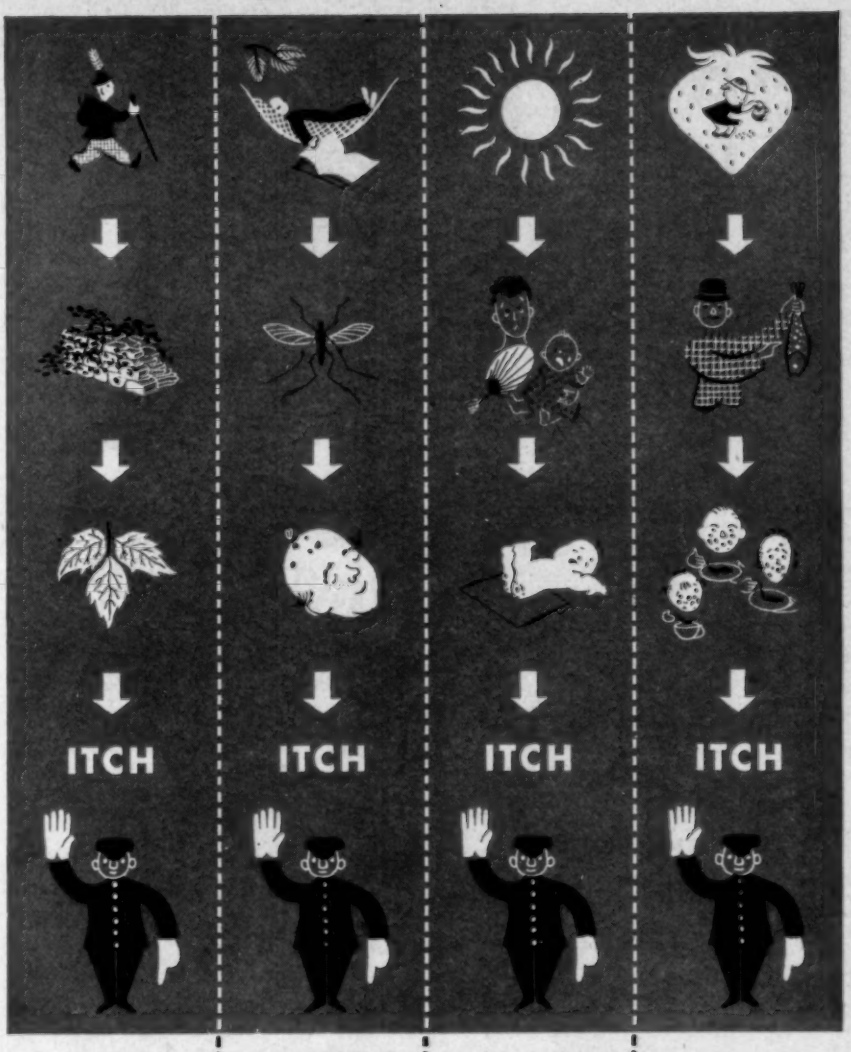
Dr. H. Jean Leeson has sound advice for nurses in connection with the value of nutrition in the healing of wounds and fractures, in chronic diseases, etc. Did it ever occur to you that when a patient is on a liquid diet or when the physician orders "force fluids" that the salt content of the blood will be sharply reduced unless special precautions are taken? This article will be most useful to every nurse for reference purposes.

Mrs. M. E. Gleadow is a member of the Air Ambulance Service crew pictured on our cover this issue. Hers is a fascinating and vigorous life. **Elva Honey** and **Louise Bartsch** are completing their work this year for their degrees in nursing at the McGill School for Graduate Nurses. **Carol M. Adams** is doing post-graduate work in New York.

Isabel Richardson and **Catherine MacLeod** are head nurses at the Saint John General Hospital, N.B., where the described Cardex system has been saving nurses' time and energy for over two years.

Frances Waugh has been charged with the responsibility of administering the Practical Nurse Act in Manitoba since its inception. She delivered this address to a meeting in Montreal. It is translated here for the information of the French-speaking nurses of Canada.

As a means of stimulating increased subscriptions to *The Canadian Nurse*, it is planned to give the figures of the distribution by provinces here each month. The paid circulation in Canada for April was: Alberta 826, British Columbia 1,168, Manitoba 409, New Brunswick 583, Nova Scotia 502, Ontario 3,289, Prince Edward Island 100, Quebec 1,064, Saskatchewan 590. Watch for your province. Help the total to grow!



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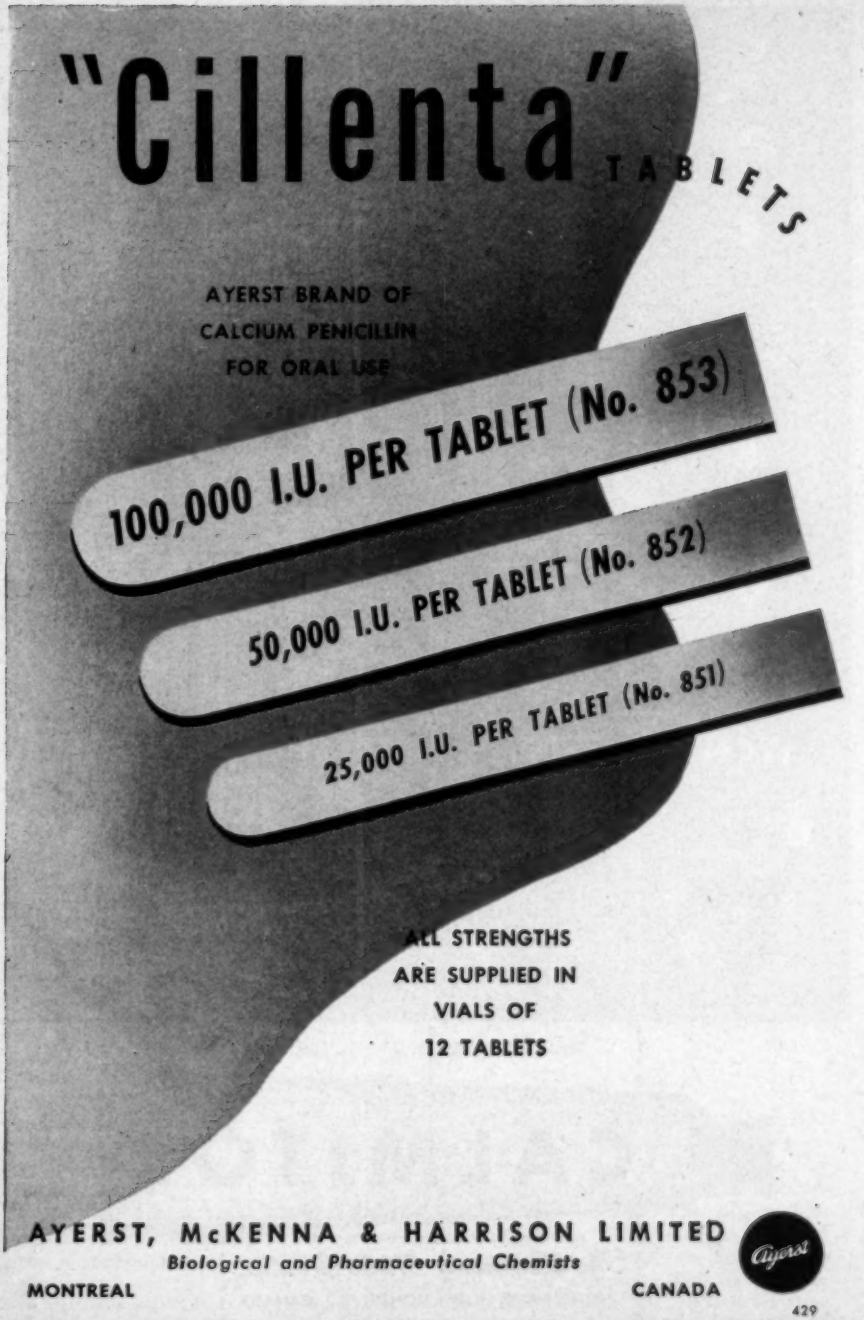
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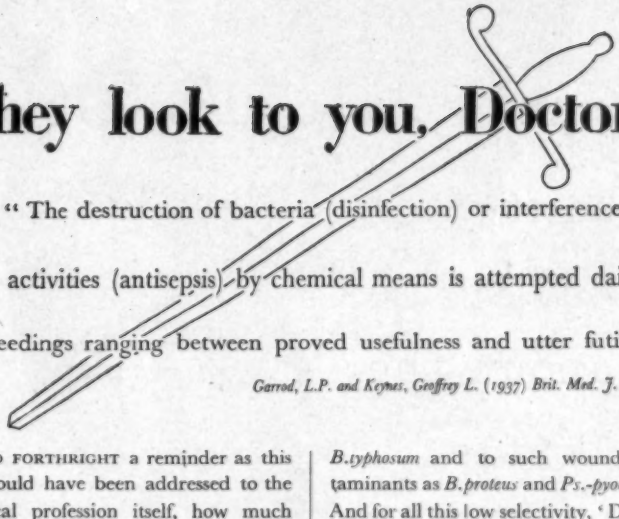

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Garrod, L.P. and Keynes, Geoffrey L. (1937) Brit. Med. J. 2, 1233.

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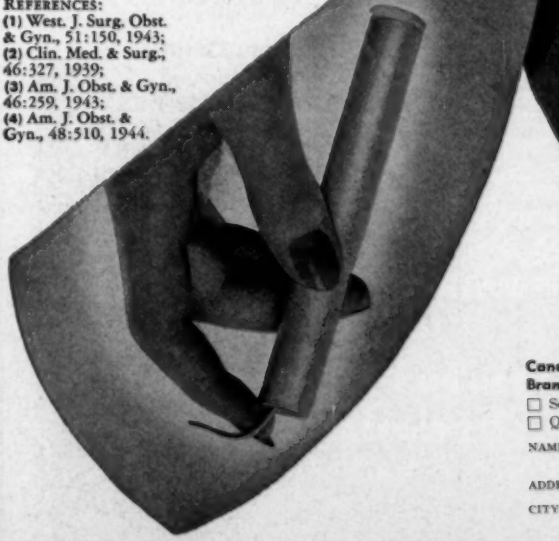
REFERENCES:
(1) West. J. Surg. Obst. & Gyn., 51:150, 1943;
(2) Clin. Med. & Surg., 46:327, 1939;
(3) Am. J. Obst. & Gyn., 46:259, 1943;
(4) Am. J. Obst. & Gyn., 48:510, 1944.



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The
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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE *NUMBER FIVE*

MONTREAL, MAY, 1947

An Equation

MAY, 1947, will go down in nursing history as the month when the nurses of the world reconvened for the first time in ten years to think and plan together, to co-ordinate nursing activities, to do their part in building a better world.

Planning for the future is excellent. But there are urgent needs today which are being tackled with skill by a few but which need the co-operation of all if the problems are to be solved. Outstanding among these is the obligation to inform the public—the men and women whom we serve as patients as well as all of their 'friends and relations,' the ominous group known as the ratepayers — regarding the difficulties and achievements of the nursing profession.

Today, on every side, we hear comments and criticisms related to the so-called shortage of nurses. As the first plank in our platform of public relations let us place the emphasis where it rightly belongs. There are more nurses in Canada today than ever before in our country's history. It is the *demand* for nursing service which has leapt to unprecedented heights.

There is an acute demand for a great many products and services today. There is an enormous demand for houses, for offices, for teachers, for nurses, for mechanics, for stenographers, for house maids, for gardeners. This excess of demand over supply is evidenced in the waiting-lists for automobiles, the queues that still form for scarce commodities, the reservations for hotels as well as for hospital accommodation. These are all parts of the same picture. To single out any one part as being more important or more acute is to overlook the significance of world events. These demands were created by and are a direct result of the years of war and altered living conditions. The use of superlatives or of potent vocabulary has heightened the problem in many respects. We hear of "grim crises," "exploitation," "dire results," etc. All the forebodings of calamity are there and yet, so far as nursing is concerned, the steadying

discipline which is inherent in our training is maintaining our response to professional demands on a relatively high level of performance.

The first requisite in any public relations program is a fully informed personnel who will carry on the education. During the war years, a broad publicity program was carried on from provincial as well as our National Office. There, news releases, radio information, booklets, pamphlets, addresses by the hundreds were presented to an interested public. One secretary spent almost her full time in making thousands of community contacts. This concentrated activity terminated with the cessation of the Federal Grant. On a smaller scale, publicity is still being carried on through the national and provincial offices but these efforts are not enough. Every nurse in Canada has the responsibility today to inform her immediate circle of the public about the positive side of nursing.

At this point, the average reader of this editorial may have one of two reactions. She will be bored and stop reading. She will be mildly indignant at the suggestion that she should "inflict" the problems of nursing on an already overburdened public. Both responses are wrong. They are indications that either she does not know what is going on, the head-hiding in the sand response, or that, being aware, she chooses to ignore her responsibilities.

No salesman can make a success of his undertaking if he does not believe firmly in the value of his product. To promote his knowledge and belief, his firm sees that he is thoroughly familiar with what the product may be expected to accomplish, wherein it excels similar products, how it can be made to appeal to the widest public, etc. In other words, he receives instruction in how to sell his product most successfully. Nurses know their product—nursing service. They have spent three years learning the various aspects of it. Unfortunately, many of the best nurses do not know how to inform the public about their work and their responsibilities. Nurses need this form of education, too. When each one of us knows and believes in the quality of service that nurses have to offer, our concerted voices will result in the long sought improvement of hours of work, salaries, living conditions, etc. The demand for nursing service is high but the understanding of its concomitant factors is low. Only by every nurse acting as an interpreter to the public, both in her professional services and her comments to those around her, will the desired objectives of public relations be achieved.

Nursing skills + education of the public = understanding + support. A problem of simple addition *if* the essential components are there! A never-to-be-solved problem of higher mathematics if either element is lacking! All of the other factors, such as the use of subsidiary nursing groups, adjustments in hours of work, salaries, etc., will fall into their rightful place if and when the nurses are ready and willing to supply the balancing integers. — M.E.K.

Preview

In his second article on new methods of treatment for venereal disease, **Dr. B. D. B. Layton** discusses what is being accomplished in the control of gonorrhea. Though it is much less common than it was a quarter of a century ago, 2.4 per cent of all blindness is still due to ophthalmia neonatorum. In spite of the routine instillation of silver nitrate into the infants' eyes at birth cases of infection still occur. To be absolutely safe from the blinding danger of gonococcus, gonorrhea itself must be eliminated. From information available it would appear that the use of penicillin as an effective treatment seems well established.

"A good diet may add not only years to one's life but life to one's years." With this introductory sentence, **Mrs. H. Ruth Crawford** opens her second valuable article in the series on nutrition. Next month Mrs. Crawford will discuss some of the problems of meal planning and preparation.

Health Education of the Pregnant Woman

GRANTLEY DICK READ, M.A., M.D.

IN THE MID-VICTORIAN era it was not difficult to have large families and to bring them up in a relatively satisfactory manner, but it is extremely difficult today and, unfortunately, although childbearing is the most important of all human functions, the mother herself has, until recently, received little attention that might make her task easier. Further, pain in childbirth has been accepted as inevitable. Obstetric teaching has made great advances in the use of drugs, analgesics, and anesthetics, but little has been done to investigate the problem of pain from the point of view of its preclusion. The use of pain-relieving devices has been so limited that they are available to only relatively few women, and this fact has undoubtedly created a fear of pregnancy in the majority of women of childbearing age.

When discussing the health education of the pregnant woman these facts must be borne in mind, for the first principle of good health is that the mind should not disturb the nervous system by doubts, anxieties, or major fears. The problem resolves itself into two lines of thought: first, the efficient preparation of the body for the purely physical function of childbearing and, second, the education of the mind to prevent the innumerable insidious ailments of pregnancy which undoubtedly arise from ignorance and anxiety.

THE PREPARATION OF THE BODY

This first aspect of the subject must be approached on the assumption that the woman has no knowledge whatever of the physiological and structural changes pertaining to childbearing and no understanding of their purpose. In the past it has been customary for women to be told nothing by expert teachers, but to assimilate hearsay and inexpert advice from women who have had babies or even those who have not had babies.

For purposes of clarity we must consider three aspects of physical education: the simple hygiene of pregnancy, physical exercises, and relaxation.

Simple hygiene: From the earliest months of pregnancy a woman should be told of the necessity for regular habits. The need for easily assimilable foods, and the avoidance of hot fats and other gastric irritants should be stressed. Her attention should be drawn to her clothing so that as she increases in size her posture may be retained without throwing undue strain on the muscles of the back, abdomen, and feet. She should be told how to support the breasts so that she may move easily and breathe freely and at the same time retain her figure when lactation has finished. There is no reason why any woman should have a less presentable figure after childbearing than before.

Exercises: It is not easy to persuade women of the necessity for physical fitness during pregnancy as a preparation for labor, but experience has shown that women who are properly prepared by physical exercises and respiratory movement have their babies with less difficulty than those whose muscles and joints have been occupied only in the routine of ordinary domestic life. Certain discrimination is advised, however, in the exercises to be performed, for they are designed not to develop the muscles but to attain maximum flexibility over their full range of action. Movements, particularly of joints, are for the purpose of mobilizing joint surfaces so that, as labor progresses, the natural strains and forces can be utilized to the best mechanical advantage. Full inspiration and controlled expiration is important. The muscles of the abdomen and the back should be regularly

exercised. The mobility of the vertebrae and of the joints of the pelvis can be increased by simple rocking movements which may be performed on the back, on all fours, or in the kneeling-squatting position.

Although the details of these exercises vary according to the different schools of physical education, the fundamental principles and their importance have happily been recognized by most of the important schools, so that minor differences of opinion may cease. As a general criticism it may be said that physical exercises are definitely worthwhile, not only because of the well-being and sense of fitness that the mother experiences, but also as an adjuvant during parturition. But physical fitness alone cannot produce easy labor. It is only one factor in the preparation for childbirth. This must be emphasized because, recently, claims have been made by writers in women's journals that physical culture provides the panacea for all the ills and woes of childbirth. Such claims lead only to acute disappointment for those who accept and act upon them.

Relaxation: It has been shown of recent years that the result of anxiety, both during pregnancy and in labor, is a state of tension in all structures supplied by the sympathetic nervous system. Morning sickness, vomiting, headache, small but noticeable rise in blood pressure, vicarious appetite, frequency of micturition, sleeplessness, irritability, and depression may all arise entirely or in part from increase of neuro-muscular tension. Far more important than these troublesome interventions, however, is the little recognized fact that the pain of normal labor is almost entirely due to abnormal tension. More will be said of this when we discuss the education of the mind, but physical relaxation is an important factor, not only in the maintenance of good health during pregnancy, but also in minimizing the pain of labor. It is simple to teach and, up to a standard sufficient to be of help, is acquired in a short time by a large majority of women.

The principle of relaxation is to adopt a position in which all the muscles of the body may be flaccid, immobile and, so far as possible, without tone. The woman should lie on her back with her feet six inches apart, her hands four or five inches from her side, her head turned over to right or left supported on a pillow. The practice is commenced by four or five deep inspirations, expiration being neither forced nor controlled. The lungs should be allowed to deflate freely. She then lies completely still, the instructor, if present, paying particular attention to the face, which should lose expression with gently closed eyes and partially open mouth. The weight of the arms may be appreciated if they lie loosely by her sides and the legs, with the toes falling outwards, will give the feeling of pressing down on to the bed or floor on which she is lying. All movements should be avoided, such as flickering of the eyelids or twitching of the fingers or toes. With very little practice this position may be maintained for ten to fifteen minutes and, when an instructor is present, the efficiency of relaxation may be tested and faults corrected. Not infrequently women will go to sleep after a very short time and such sleep is likely to be restful, dreamless, and undisturbed. The best times for relaxation are in the middle of the day and upon going to bed at night, and it is most effective if carried out after the exercises have been performed.

The application of relaxation in labor is to avoid all tension during contraction in the first stage, for neuro-muscular tension of the skeletal muscles is undoubtedly associated with an increased tension of the constrictors of the lower uterine segment, and if from any cause the woman herself is in a state of tension, the dilatation of the cervix by the longitudinal muscle fibres of the uterus is subject to increased resistance. In the second stage of labor, relaxation between the contractions not only increases the rate of recuperation but also

intensifies the natural amnesic state which is a physiological provision to minimize exhaustion from the violent physical effort of expulsion.

The physically fit woman trained in the art of relaxation almost invariably has a quicker and less distressing labor than a woman who is not physically fit and who remains in a state of neuro-muscular tension. But again emphasis must be laid upon the fact that relaxation is only an adjuvant to natural labor and by itself is not sufficient to give the best results.

The Education of the Mind

This is undoubtedly the most important part of the prenatal education, for the woman who is taught about the processes of childbirth and who experiences its changes with neither surprise nor dismay but who appreciates the significance of the series of natural events as they develop, has every chance, in the absence of complicating features, of producing her child easily and happily in a state of physical fitness and mental equilibrium. No man or woman in modern civilized communities is expected or invited to undertake an important task without reasonable instruction, and yet for centuries woman has been asked to carry out this most momentous task, unguided and uninformed. It is not unnatural that labor has earned an unjustifiably evil reputation.

From the beginning of pregnancy, therefore, every woman should be instructed in a simple way. She should be told the elementary anatomy and physiology of her organs of reproduction and thereby have reason to respect and care for them. As the infant grows, she should be kept aware of the necessities for its protection and nutrition and should have at least a rough idea of its size. With the advancing months new facts can be given to her, and her fears eliminated by honest instruction. The beliefs of the past should be replaced by the realities of the present. The necessity for physical preparation will dawn upon her and an interest in her condition, her baby, and the conduct of her labor will alter her whole attitude towards childbirth. She should have someone whom she may question so that no doubts can form a background of anxiety in her mind.

By the thirty-eight or thirty-ninth week she will be ready to rehearse the actual position in which labor is conducted. She will be acquainted with the manner of its onset and the signs by which she may recognize its commencement. She will be told of its stages and how pain can be both prevented and caused. The importance of her physical training and the practice of relaxation will dawn upon her, and almost invariably the average woman will look forward with determination to carrying out her labor according to the law with which she has been made acquainted. She develops confidence through understanding; she develops faith in her attendant, particularly if the instructor may be present at her labor; but, most important of all, she looks forward without apprehension, not to a simple affair to be taken frivolously, but to a day of honest hard work, concentration and control, which will enable her to avoid both pain and danger and protect her child from unnatural interference.

Results of Prenatal Education

This prenatal education, both of the body and the mind, is already being undertaken at a number of antenatal clinics throughout the country. It has been found that very little extra time is needed, particularly if some of the redundant and unnecessary items of routine are dispensed with, and the results obtained have already more than justified any reorganization which may have been necessary.

There is no class in obstetrics — from the illiterate to the most highly educated similar variations will be detected. Taken by and large, one of the most surprising observations is the ability of all women to understand such education as has been described above. A pregnant woman has

a mind that is reaching out for information about childbirth and, although different words may be used to different people, the comprehension of these matters is remarkably facile. Where this instruction is given, usually in classes of twelve at a time, the whole atmosphere of the antenatal clinic is changed. Women arrive cheerfully with obvious buoyancy of spirit with a demand to know more and to improve their educative technique. A large majority of them appear, as indeed they are, cheerful enthusiasts whose anxieties have been cast like a burden from their shoulders; they have become bored with waiting during the last fortnight; they have become exhilarated when they recognize the onset of labor.

If labor is conducted with full knowledge of emotional as well as physical changes it presents a new picture of parturition. It becomes a peaceful, quiet performance with the pain period only noticeable at the stage of transition from the first to the second stage. The woman will have been forewarned of this and will have realized that it is a temporary discomfort which will be relieved if she considers it unjustifiably intense. She will be told that when the birth canal is open wide enough to allow the child to be expelled, her uterus will call upon her to give involuntary and strong assistance. If the phenomena of labor have been outlined to her beforehand she will not be, as most untrained women are, in a mental turmoil, anxiously awaiting the worst and unbearable pains which they believe to be inevitable.

In a series of a hundred consecutive deliveries of trained primiparae and a hundred cases of unprepared controls recently conducted at one of our universities, labor was over four hours shorter in the trained class than in the untrained. Minnitt's analgesic apparatus was offered to and available for all the women. It was used by 5 per cent of the educated and 76 per cent of the uneducated. This difference was not due to gallantry or to loyalty to their teachers, but because they neither needed nor wished for it. There is little doubt that these results would have been even better had the attendants also been trained in the conduct of physiological labor, but they were not and consequently much of the antenatal education was robbed of its advantages.

There is no reason why this important training should not be carried out wherever antenatal clinics are held. Although it has been adopted by many, and it is rapidly being organized by more, this great campaign, not only for the relief of suffering in childbirth but for the fearless happiness of motherhood, must be encouraged. There is no justification for the denial of these benefits to women. Physical Training Colleges (in Britain) are prepared to give special courses for the instruction of teachers in obstetric physiotherapeutics who will be competent to attend women during labor. With the shortage of nurses it will be of assistance in our maternity departments where women under present conditions have to be left alone for many hours during the first stage of labor. Loneliness, mental or physical, is one of the causes of painful parturition.

There is evidence from all over the English-speaking world that this teaching has brought safety and happiness in motherhood. It is hoped that in the near future one of the fundamental principles of obstetrics will be that all women are educated and prepared for the fulfilment of their ultimate perfection as the females of the human species.

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The above article, supplied by the League of Red Cross Societies, is reproduced with the kind consent of the author and of the Central Council for Health Education.

Delivery Room Technique

GERTRUDE ARMSTRONG

THE DELIVERY ROOM service is by far the most important part of the Obstetrical Department. It must be well organized, and the equipment and supply of linen must be sufficient to ensure an uninterrupted twenty-four hour service. The staff of graduate nurses must be qualified and experienced, and the student nurses well supervised. The whole personnel must give of their best at all times, for in no other part of the hospital do the combined efforts of physician and nurses mean so much to the patient's welfare, as a split second may sometimes spell life or death.

Our hospital has a large Prenatal Clinic, where expert care and advice are given to expectant mothers, but we still have a great many emergency cases come to us who have had little previous examination.

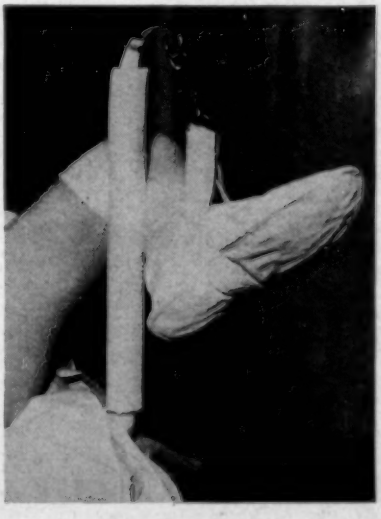
Nurses on duty in the Delivery Room wear gowns over their uniforms, tight-fitting caps and masks which are discarded after two hours' usage. Each patient is provided with individual equipment: bed-pan and tray for perineal care. These and all linen are autoclaved. The mattresses and pillows are covered with detachable rubber sheeting, which is easily washed with soap and water after each patient is delivered. All patients' clothes are listed and placed in a locker room adjacent to the Admitting Room, thus eliminating any outside contact.

When a patient is admitted to hospital, she is first examined in the Admitting Room by an interne, who, having previously looked up her prenatal record, observes her physical condition, does a rectal examination, takes her blood pressure, and examines a specimen of urine. The abdomen is palpated and the fetal heart sounds counted. All these findings are recorded on the "Labor Sheet."

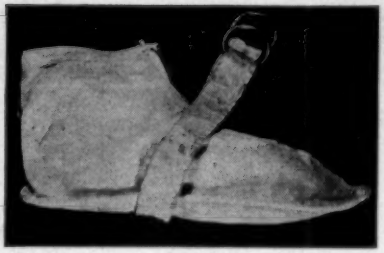
The nurse, wearing a gown, then proceeds to prepare the patient for the Labor Room. If time permits, a sponge bath is given, the hair is fine combed, an enema given, and the pubes shaved. The patient is then taken to the Labor Room. The nurse puts on a fresh gown, scrubs her hands, and proceeds with the preparation of the patient.

All equipment for the "scrub up" used for the patient on admission to the Labor Room, preceding a vaginal examination and at time of delivery, is kept on special tables which can be easily wheeled from room to room. Each table is covered with a sterile towel folded so that half of the towel covers the equipment which consists of: 1 hand towel; 1 pair rubber gloves; 5 pad filler squares; 2 bowls (one filled with green soap and sterile water and the other with Dettol Solution 2%).

Perineal care is given each time a bed-pan is used. The pulse, temperature, respiration is taken q.4.h, and all intake and output charted. The fetal heart is noted by the nurse q.15 min. All care and contacts with the



The stirrup in use



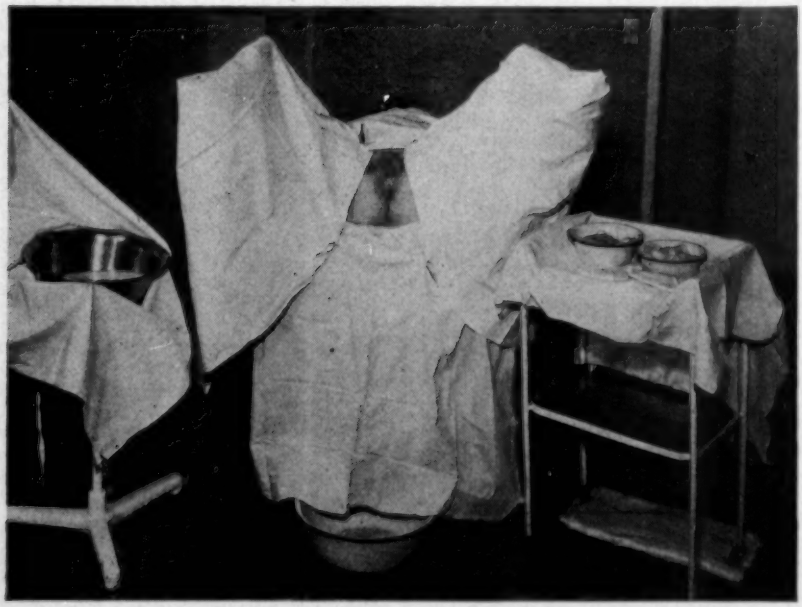
Delivery boot—side view

Delivery boot—front view

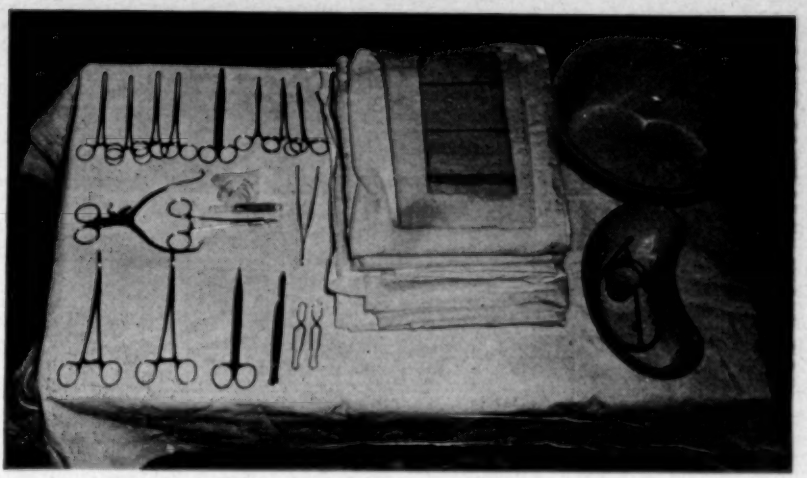
patient are recorded on a "Treatment Sheet" designed for this purpose.

Immediately before delivery, Dettol Cream 30% is applied to the perineum, and the patient is catheterized with a rubber catheter.

The delivery stirrups consist of straight padded poles and a pair of washable boots. These delivery boots are zippered over the cotton stockings and suspended from the upright bars by means of a strap attached to the boot. The zippered boot permits easy manipulation and prevents the foot from slipping out of the stirrup. The straps are sewn to the sides of the boot so that pressure is distributed over the plantar surface of the foot. There is no circular pressure around the foot or the ankle as in other methods. When the patient "bears down" her feet are supported and the cramping



Draping of patient and equipment



The instrument table *Hayden, F.R.P.S.*

muscular spasms of the legs are eliminated. She also has mobility of the legs when awake. When the patient is anesthetized the legs become abducted by their own weight. These boots are inexpensive, washable, and comfortable. The accompanying illustrations show the type of delivery boot which we use. They have been adapted from the style used by Dr. J. B. Pastore.*

The following packs are used in the Delivery Room:

A. *For vaginal examination:* 1 draw sheet; 1 small perineal sheet; 1 hand towel; 1 vulva pad; 5 gauze sponges.

B. *For delivery:* 1 large sheet (fan-folded to cover table while awaiting delivery and later used to cover baby's cot); 1 pair leggings; 1 square sheet for use under buttocks; 2 draw sheets (one for each leg); 1 square sheet doubled (this is used to cover abdomen); 1 large towel (placed across the perineum); 1 cotton bag containing gauze sponges and cord ties; vulva pads.

N.B. This type of draping prevents contamination if patient is restless and not deeply anesthetized.

C. *Equipment:* In a special double cover, opened at side and end, are placed: 1 hand basin; 1 placenta basin; 1 kidney basin; 1 specimen bottle for urine.

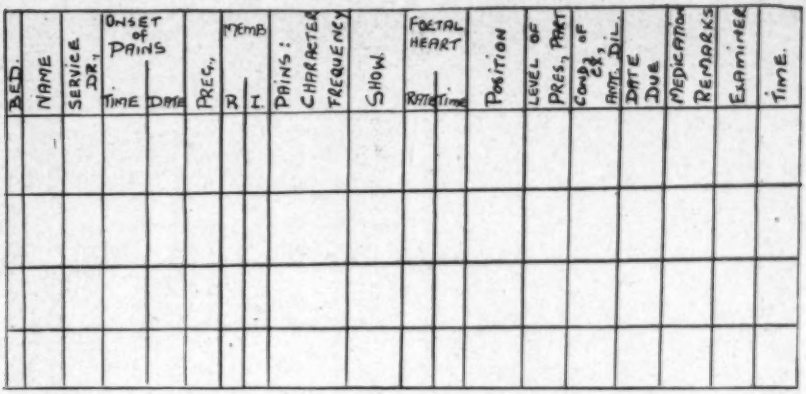
This covering is used as a hand basin stand drape which can be kept covered if necessary until needed.

D. *Instruments:* The instrument table is set up as shown in the accompanying illustration. We keep a photograph of this table set-up in every Delivery Room; this has proved a great saving of time and helps the student nurses.

A large blackboard is placed on the wall in the corridor of the Delivery Room Suite — the headings covering the progress of labor for each patient are shown in the cut. This is valuable for the teaching of nurses and medical students, as well as a source of information for the doctors and nurses, and lessens the number of contacts which otherwise would occur.

If the new-born infant does not breathe spontaneously assistance is given immediately. The air passages are cleared of mucus with the aid of a mouth suction tube. Breathing may be stimulated by means of resuscitating tubs, resuscitating machine, or gentle massage of the chest. Oxygen 95% and carbon dioxide 5% or oxygen may be given to further stimulate breathing. Alpha lobelin, coramine, or adrenalin may

* *Reference:* "A Satisfactory Leg Support for the Lithotomy Position," John B. Pastore, M.D., Department of Obstetrics and Gynecology, Cornell University Medical College and the New York Hospital.



be injected as ordered by the physician.

Good case room technique demands a great deal of forethought; it means the conservation of time and energy, and plays a major part in assuring better nursing care to the mother and her new-born child.

Homestead Obstetrics

BETH LAYCRAFT

IS IT A CITY HOSPITAL with elaborate and fine equipment, with anethetists, doctors, and nurses galore? Or is it a homestead cabin with a few simple instruments set up on a dresser with the husband and a neighbor woman to help the nurse? Basically the objects are the same — a healthy mother and baby with a maximum of safety and comfort. We Alberta District Nurses sometimes find ourselves in the second set-up and I am going to outline briefly what we do in this area where doctors are so scarce.

I will take you through a pregnancy with an imaginary Mrs. John Smith whose case is typical. Mrs. Smith, a twenty-two-year-old primipara, comes to see me in the second month. She is obviously both frightened and pleased by her pregnancy.

Much depends on this first visit. If it is well handled Mrs. Smith will receive guidance and help through a critical period and, equally important, she will place her confidence in the nurse and seek her counsel in other family problems. Regardless of the pressure of other business I never hurry this first visit. First a careful medical history: infectious diseases, rheumatic fever (beware the heart!), serious illnesses, operations, pertinent family history. I check the temperature and pulse, take her weight and height. Is her thyroid enlarged? Teeth or tonsils need attention? Any varicosities? Breasts seem normal? How is she sleeping? How is she eating? Any nausea? I estimate her hemoglobin and take blood for a Wassermann.

I take the pelvic measurements. If the nurse is not accustomed to using a pelvimeter a well-illustrated text will guide her. I measure the interspinous, intercristal, intertrochanteric, external conjugate, and bisischial diameters. At the fifth or sixth month when vaginal examination causes little discomfort, I estimate the diagonal conjugate.

This measurement is considered the most important.

The old women have already scared Mrs. Smith half to death with their tales and she is too shy and frightened to ask about the things that trouble her. This is where I can help by bringing some of the problems up. She wants to know if she can have marital relations? Is it true a fright will mark her baby? What about rest and exercise? What should she eat? As soon as the first barriers of shyness are down the questions pour out. I take plenty of time and answer them carefully.

I don't forget that there is a father in this family too. Very often at this time the father feels crowded into the background and his place usurped. I draw Mrs. Smith's attention to this and she will handle the rest. I like to discuss her condition and the care she needs with him too. When Mr. Smith undertakes to supervise his wife's health, under the tutorage of the nurse, it may be understood she will not vary much from the prescribed course. Later, if he is personally responsible (taught by a smart wife) for the bottles and diapers, and sometimes even for the morning bath, it is a lucky baby and lucky parents too.

I give Mrs. Smith a copy of the *Canadian Mother and Child* and some literature on diet and baby care which she and her husband will read together.

At each monthly visit I check her weight and blood pressure, do a urinalysis, determine the height of the fundus, the baby's position and the frequency of the fetal heart. Minor disorders are attended to; anything serious is referred to the doctor. Iron and cod liver oil are added as needed to her diet.

After the seventh month I like to see her more often. If the distance is great and the roads rough (as they often are in northern Alberta) I would consider it unwise for her to travel but would try to visit her and would have her husband bring a sample of urine and word of how she is feeling.

At eight and a half months Mrs. Smith is feeling very well. The baby is in the L.O.A. position and appears to be of average size. Rectal examination reveals that the head is engaged, that is, the bony presenting part is within 1 cm. of the level of the ischial spines (the baby's head is the best pelvimeter). There are no contraindications to home delivery such as pelvic disproportion, malpresentation, symptoms of toxemia, or bleeding, and I agree to take the case. If there was any reason to anticipate trouble I would send her record to the doctor and ask her to go to the hospital for her confinement.

During the last two weeks she takes one vitamin K capsule daily—a cheap and easy precaution for both mother and baby against hemorrhage.

I explain the symptoms of the onset of labor and tell her to call me as soon as labor is definitely started.

I like to see the home before the time of delivery and at Mrs. Smith's I find a one-room log cabin. There is a good lamp and a bed with good springs and a firm mattress. Her mother, Mrs. Croft, who lives near, will come to help her when labor starts.

The maternity bag is a sturdy overnight bag, 18 x 12 x 6, with a snap-in cotton lining. A "sterile" technique is practically impossible in our bags but a "clean" technique is strictly carried out. The bag from the lining out is packed fresh after each case with clean, ironed linen, and freshly boiled instruments. Nothing is used which has not been boiled since the last case.

Equipment

In the maternity bag we carry:

2 large enamel basins about 8" diameter; 1 small enamel basin; 2 large kidney basins; 2 Papricloth sheets (heavy sterile wax paper); 1 safety razor and blades; 2 catheters — soft rubber; 1 Murphy drip bulb with a catheter to be used as a mucus suction tube; 2 rectal gloves with a powder puff and lubricant in a small box; 3 pr. rubber gloves — two to be boiled and an extra pair in case of accident;

3 masks, one for the nurse and one for two assistants; 1 gown.

1 many-tailed binder; 2 hand towels; 1 chloroform mask; 1 chloroform dropper; 1 hypodermic syringe, hypodermic and intramuscular needles, suture needles; 1 nail brush; 2 medicine glasses; 1 baby scale; 1 clinical thermometer; 1 rectal thermometer; 1 eye dropper; 1 sterile jar, cord tape; 3 obstetrical sutures in glass vial; cord powder; 1 test tube for cord Wassermann.

Instruments: 1 pair scissors; 4 cord clamps (extra two in case of twins); 1 needle driver; 1 toothed tissue forceps; 1 ring forceps.

Solutions: Green soap; Dettol; Dettol Cream; alcohol; olive oil.

Drugs: Silver nitrate 1% in wax capsules; chloroform; castor oil; local anesthetic; ergotrate tablets; quinine gr. v; aspirin compound with codeine gr. ¼; Synkamen capsules (vitamin K).

Hypodermic drugs: Morphine gr. ¼; Demerol 50 mgm.; ergotrate ampules; pituitrin ampules; coramine ampules; Synkamen ampules.

Sterile supplies: Vulva pads: 2 packages of 4's, usual size, 2 packages of 2's, 4" x 8"; pledgets; gauze squares to be used for cord dressings and wiping eyes, nose, and mouth of baby.

Other articles which may be carried in the Stanley bag are: sphygmomanometer; stethoscope; bivalve speculum; paper towels; pencil and paper.

In a separate bag, I carry a bed-pan in its own cover, a Kelly pad, and a bundle of newspapers.

The Delivery

Mrs. Smith begins labor and calls me. She has been having pains for four hours and rectal examination reveals that the cervix is half dilated. I check the L.O.A. position, count the fetal heart, and take her blood pressure. I shave the vulva and give a soap-suds enema. If the bladder appears distended and she is unable to void, I catheterize her.

Mrs. Smith keeps about during first stage and shows me the baby clothes. I show her and her mother, who has arrived, how to sterilize the pads by baking them in the oven in a small sack for half an hour at about 300° F. Then we get something to eat. All this distracts her attention and helps her to relax while the cervix is dilating.

If it is needed, I give 100 mgm. of Demerol. A repeat dose of 50 mgm. may be given three or four hours later. I do not give any sedative if I expect the delivery within four hours. A surprising number of cases need no sedation.

I get everything ready for the delivery in plenty of time. I put water to boil in one large basin and cover it with the other. A saucer is boiled in this basin to remove clots and debris from the bed after the delivery. Just before I scrub, I uncover the basin and add Dettol to the water to be used as a sterile hand basin. In the other I put sterile pads, absorbent and dressings. In one large kidney basin, covered by the second, I boil instruments, sutures, syringe, needles, and a medicine glass. Later I fill the medicine glass with Dettol Cream. The second kidney basin will receive the placenta. I boil an extra pair of gloves in a saucepan for any unexpected emergency.

Mrs. Smith prepares the baby's basket and tucks in a hot water bottle.

When rectal examination reveals that the cervix is fully dilated I instruct Mrs. Smith in bearing down. If the second stage is progressing slowly it often helps if, during the pain, she assumes a squatting position like that used by many primitive women (it increases the diameter of the outlet and assists her bearing-down efforts). Patience and gentleness are the nurse's best qualities.

For the delivery I like the bed raised to a table height by placing twelve-inch blocks under the legs. The patient lies transversely across the bed with the buttocks close to the edge. Two chairs at the edge of the bed with pillows across the backs will make stirrups. I put warm stockings on the patient and a blanket across her chest and arms. I prepare the sterile field and just before I scrub I slip the sterile Papricloth sheet under her.

I put only one ounce of chloroform (for everyone's protection) in

the drop-bottle and show Mr. Smith how to drop it on the mask. I will direct him to give it for the last few pains during the birth of the head.

Remembering that the helpers are the greatest potential source of infection I explain what is sterile and why they must not come near it. They co-operate very well. I give them each a mask and ask them to put on clean aprons.

I put on a cap and a clean (not sterile) gown and then scrub. A small amount of soap left on my hands will permit the wet gloves to slip on easily.

In the District, it seems wise to avoid episiotomies or tears if possible, so we keep the head on the perineum until it is very thin. I keep the head well flexed until it is crowned and then between pains allow it to extend slowly and the head is born. I wipe the nose and mouth and note the head will turn right. I cannot feel the cord around the baby's neck. I grasp the head and turn the baby so the shoulders are in the antero-posterior diameter of the outlet. I draw the head down to bring the anterior shoulder under the symphysis and then raise it gently to avoid a tear by the posterior shoulder and the baby is born. The suction tube and catheter clean the nostrils and throat. I tie the cord about two inches from the abdomen and then fold it back and, using the same tie, tie it again. If it should tend to bleed there is still room to tie it again.

I always give the new-born baby to its father to be put in its basket. And isn't he proud to be the first to handle it! I can hear him clucking and talking baby-talk to it while I tend to the placenta.

A hand on the fundus. It is firm and hard. I inspect the perineum. Good! no tear. There is a gush of blood and the fundus rises up in the abdomen. Now a whiff of chloroform while the placenta is born. When it is at the vulva I grasp it with both hands and turn it gently till the membranes are detached. I examine both the placenta and membranes to be sure they are intact and take blood for a cord Wassermann.

Postpartum Care

Mrs. Croft helps me move the patient into a comfortable position and I show her how to hold the fundus while I tend the baby. The bleeding is not excessive but I usually give an ampule of ergotrate to be sure.

The baby is a vigorous boy — seven pounds ten ounces. Silver nitrate 1% for the eyes. No tongue tie, genitals appear normal, anus open. I clean him as much as necessary but do not remove the vernix caseosum. The cord is sponged with alcohol and a sterile dressing applied. I dress him and put him in bed with his mother. He will go to his own crib before I leave.

Everyone is hungry, including the new mother, and we all enjoy a meal. This extra hour before I go is another hour in which I can watch the mother and baby.

I leave the following instructions with Mrs. Croft for Mrs. Smith's care:

Pain: If she is in pain give her one "pain tablet" every four hours if necessary. (I leave six aspirin compound.)

Bleeding: Give one "bleeding tablet" (ergotrate gr. 1/320) morning, noon, and night for two days. The uterus can be felt like a round, hard ball in the abdomen. It goes down about one to two inches each day. After delivery it is at the navel. It should never rise above it or become soft. If it does there is probably bleeding inside even though the patient may not be flowing much. If there is either a large, soft uterus or more bleeding, give a tablet immediately and rub the uterus gently until it becomes hard. (Before I leave I make sure that this is well understood.) Send for me unless the bleeding stops immediately and the uterus stays low and hard.

Bowels and bladder: A full bladder displaces the uterus and slows its return to its normal size and position, so give the bed-pan at least every four hours. Do not put it on the floor as it will take the dirt from the floor to the bed where the patient lies.

After emptying the bladder the patient may use toilet paper. After a

bowel movement the assistant should wash her hands and then with soap and water and a clean towel and cloth very carefully wash away from the vagina. Be careful that nothing goes inside. (We find that in untrained hands the usual hospital perineal care is poorly given and may be a source of infection.)

If the bowels have not moved by the second day give a mild laxative. If they have not moved by the next morning give her an enema.

Care of the breasts: If the breasts are heavy support them "up and out in the shape of a pear" by a binder. A piece of absorbent cotton or half of a pad under each breast will help. Make broad firm straps for the binder and adjust their length by a safety pin.

Wash them with soap and water before the baby nurses. Keep a cloth and towel separate for this.

Put the baby to nurse on alternate breasts for not more than two minutes every six hours until the breasts fill, then every three hours during the day and every four hours at night. The baby will go on a four-hour feeding itself when it is ready.

Diet: The mother may have light nourishing foods as she desires them—plenty of fluids and milk. If the breasts become painful and hard, lessen the fluids for a day.

Visitors: No visitors until after the fourth day. The mother needs rest and neither she nor the baby should be exposed to sore throats and colds which visitors may bring.

Danger signs: Send for me immediately if any of the following occur or if anything else seems wrong with the mother or baby:

Pain in one breast (engorgement will be in both); excessive bleeding; abdominal pain and a general sick feeling; pain in one leg; fever and chills; failure to pass water within twelve hours; bleeding from the baby's cord.

Care of the baby: Wash the buttocks with water and soap when necessary but do not bath him for six days. Change the binder if it becomes wet or soiled. If the dressing becomes wet, wash your hands thoroughly and put on a fresh one.

I return on the third or fourth day to check the mother's progress and to start her exercises. As there is a tendency for women in their own homes to go to work too soon I like them to stay in bed for nine days. If I can, I make another visit then for health instruction and supervision.

In six weeks, Mrs. Smith comes for a postpartum examination. She is feeling and eating well and is doing her own housework. She is nursing the baby and there is plenty of milk. Her weight is slightly more than in her pre-pregnant days. The cervix appears normal. The uterus cannot be palpated above the symphysis and there is no vaginal discharge. I put the baby on the usual Well Baby Clinic care and ask Mrs. Smith to come for another check at six months. Then I will finish her obstetrical record and file it for future reference.

We district nurses take much pleasure in this part of our work and find it makes a valuable contribution to public health.

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Pain

Pain arising from the skin can be accurately localized. Pain from visceral disease cannot be localized with the same degree of accuracy because the nerve-endings are segmental in distribution. Pain is localized on the skin because the cortical analyzer has been educated. The skin can be seen, and as the cortical analyzer gains experience, it learns to localize skin pain accurately. In the case of deep pain there was not that learning by sight combined with experience, and the area in which pain is felt depends on the general sensory nerve distribution.

—*Nursing Times*

Care of the Unmarried Mother and her Child

N. W. PHILPOTT, M.D. *and* CHRISTINA F. GOODWIN

TRADITIONALLY, unmarried mothers have turned to the medical profession for help and advice. They have looked for an unprejudiced attitude towards their problem, a safeguarding of their confidence, and practical assistance for themselves and their babies. They have asked a great deal of the profession and doctors have not shirked their responsibilities.

Gradually, another profession has been growing up — that of social work — to which doctors have been turning. Today some social workers give all their time to the problem of the unmarried mother and her child. They are ready and, in many localities, are working with the doctors to provide the best possible solution for mother and baby. As the doctor thinks of each patient individually and plans according to her particular physical needs, the social worker gives consideration to each unmarried mother's social and emotional needs. This is an age of specialization, and doctors, most of all, are able to see the necessity of assistance for the unmarried mothers and their babies from a profession specially trained and experienced in this very difficult work.

Unfortunately, there have been few funds available for research on the effects of unmarried parenthood, on the success of adoption or of the mother retaining the responsibility of her child. It is, therefore, impossible to make statements about what plans are best in the majority of cases but we can put down some basic principles on which we work.

We believe that every unmarried mother should have freedom to choose whether she will keep her baby or give it up for adoption. This involves a great deal, as it implies that she will not be forced to a decision through economic necessity alone; that she will not be advised in such a biased way that the decision is really that of her adviser; that fear, shame, and guilt will not weigh so heavily on her that she cannot think through her problem. These patients are in a defenceless position where they may very easily be influenced to make hasty decisions which they will regret all their lives. The doctor is in a strategic position to guide them towards resources in the community where they may get help to make it possible for them to delay decision till they are fit for such an important task. In most cities in Canada there are private agencies who specialize in these services and in most provinces the Children's Aid Societies cover even the rural areas. In hospitals, which have social service departments, much help may be secured through them for the unmarried mother.

Doctors recognize that all pregnant women have some psychological and emotional problems. A woman, who does not have the normal support and protection of a husband but who has very often a sense of guilt and shame, a feeling of bitterness towards the father of the unexpected baby, or towards parents who have not prepared her to avoid such a tragedy, has much more complicated psychological and emotional problems. Sometimes these are so severe that she needs help from a psychiatrist. It is true that few unmarried mothers are in condition to decide the fate of their babies until they have recovered from their confinement and are normal physically. They need to have full information as to the resources available to them and particularly to

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know just what will happen to the baby should they give it up for adoption. Some mothers, who have no contact with their babies after birth, later make efforts to trace them, an evidence of an unsatisfied need and sometimes a continuance of a feeling of guilt. It should be recognized that an unmarried mother, in addition to the physical pain of giving birth, has psychological suffering which is not so quickly forgotten. It is probably true that if the mother sees her baby, does something for it such as feeding it while in hospital, or paying what board she can for it till it is given up for adoption, she may overcome her feeling of guilt. Some psychiatrists teach that you must possess before you can give up. This may well apply to the unmarried mother.

It is important that those who try to help the unmarried mother should understand her motives in making decisions and should be able to interpret them to her if they are unsound or unhealthy. You cannot assume that love or hate of the baby always lead to the same end. Some mothers give up their babies because of an honest belief that it is in the best interests of the baby. Others do so because they reject them as visible evidence of their feeling of guilt or because they associate the baby with its father, towards whom they feel bitterness. The social worker can help the mother to think of the baby as an individual for whom they should plan to the best of their ability. They direct their emotions in healthy channels and facilitate their return to a normal mental and emotional condition.

Sometimes relatives and friends put pressure on the unmarried mother in making her decision. They may overprotect her with the idea that she should forget all about the unfortunate experience, or they may try to make her feel guilty if she decides to give up the baby, as "no baby should be separated from its mother" or "nothing would make them give up their baby." Even should they give up their babies they still need contact with a professional worker in whom they can confide their worries and who can reassure them as to their decision.

It is difficult to make any definite statements as to what type of mother can succeed in making a fairly normal and happy life for her baby should she keep it. Those who marry and whose husbands adopt the babies are sometimes successful. If the mother is emotionally stable and the conventions of her family and social group are not too violently critical of illegitimacy, she may succeed in bringing up the child in her parents' home. The occasional gifted woman can manage to make a home for herself and her child alone.

When the mother decides to give her baby for adoption she should be advised to do so through recognized agencies or welfare departments of the Government, which are professionally staffed. The selection of adoptive parents, the placement of babies in suitable homes, and the supervision of the babies until adoption procedures are completed, is a very difficult task which should be done by professional persons trained for that purpose. All doctors must know of tragic cases where insufficient care has been taken to be sure that the couple wanting to adopt a child is fit or capable of looking after it, or where the baby has not been fit for adoption. Some childless women become so emotionally unstable in their anxiety to have children that they cannot give a baby a normal, secure environment. Sometimes the husband does not really want to adopt a child, is over-persuaded by his wife, and does not accept the child emotionally. Sometimes there are health factors which render the couple unsuitable as parents. Infinite care should be taken that the baby who, from its family background and elementary intelligence tests, shows potentialities for more than average mental development should be placed with parents of above-average intelligence, who can provide full educational opportunities. Like care should be taken that a baby of only average intelligence

should not be placed with parents who will expect the impossible of him and make themselves and the child frustrated and unhappy. Experience has shown that it is best for the child that foster parents should tell him of his adoption as soon as he is able to understand it. There have been a number of cases in mental hygiene clinics where children were found to be developing behavior problems because of their doubt as to parentage. When this is explained to them at an early age there is the least danger of emotional trauma.

Persons who arrange adoptions must, of course, be conversant with the child protection laws of the province in which this is to be carried through. There have been needless heartaches for unmarried mothers who have been offered this service only to find that it could not be carried through as planned because of some legal technicality, such as residence regulations.

During 1945 there were 2,438 deliveries in the Royal Victoria Montreal Maternity Hospital. One hundred and one unmarried mothers were capably handled relative to their own condition as well as to the future of the child. This was a combined effort of the medical staff and of the social service department. The majority of cases were attending the prenatal clinics, many referred by agencies, but some were private patients referred to the social service department by their doctors.

All new patients registering at the prenatal clinic are first seen by a social worker and, therefore, the unmarried mothers are very early offered the services they particularly need. No definite plans are made until patients have been examined by the doctor and his recommendations have been received. Sometimes it is necessary to know the patient's fitness for work, or whether her living conditions are suitable to her physical needs. Sometimes a decision must be made as to the advisability of the mother travelling in order to reach a place where she has legal residence and is eligible for financial assistance, or where she may arrange adoption. The doctor and social worker must consult together about these patients on many points and also keep closely in touch with the agencies interested. In Montreal we have four different agencies which look after unmarried mothers and their babies: the Children's Aid Society of Montreal, the Catholic Welfare Bureau, the Bureau d'Assistance Sociale aux Familles, and the Jewish Child Welfare. There is also an agency which takes responsibility only for the babies — the Société d'Adoption et de Protection de l'Enfance. This hospital works closely with all these agencies.

Sometimes the social worker in the hospital must spend a good deal of time and effort to persuade a patient to give her consent to a referral to any agency, but it is always considered worthwhile. Even when the unmarried mother thinks she is capable of planning for herself and her baby experience has proved that she needs this protection. It also protects the baby from being exploited. The public is becoming more and more aware of this danger. As an example, at the Canadian Conference of Social Workers held in Halifax, June, 1946, Miss Maud Morlock, of the Children's Bureau, Washington, told how women eager to adopt babies were coming to Canada from the United States and taking them across the border without any proper supervision. Among other difficulties the children later on find that they have no citizenship rights.

In Montreal, a group of social workers and agency board members have formed a committee on unmarried parenthood, under the Council of Social Agencies, to study such problems and to make recommendations to the authorities for improvement of our Child Protection Laws.

There must still be many unmarried mothers who do not receive adequate prenatal care and whose babies are not placed. Facilities for adequate handling of this type of case should be made available to the whole community and not confined to the larger institutions.

Optimal Nutrition for Patients

H. Jean Leeson, M.D.

It is the nurse's responsibility to look after patients' nutrition, because ultimately she is the only one who can make sure that the patient actually consumes the proper amount and the kinds of food prescribed by the physician. The problem is rendered more irksome by the fact that her choice of the patients' diet is limited: in hospitals by the quality and kinds of food prepared in the kitchens; in private homes by economic and other factors. In view of these restrictions the nurse's knowledge of proper nutrition does not ensure that her patients will obtain an optimal diet. However, a clear mental picture of the goals of invalid feeding will enable her to choose the best available from the foods at her disposal, and make intelligent suggestions about improving them.

The nutritional needs of the human body are fundamentally similar throughout life, both in sickness and in health. In certain normal conditions, such as the rapid-growth period of adolescence, pregnancy and lactation, these needs are increased. Similarly in some diseases, such as hyperthyroidism, or long-standing or recurrent febrile illnesses, metabolism is increased and there is need for a larger amount of all the nutrient factors. Conversely, in non-febrile illness the patient on full bed-rest has a decreased caloric requirement. Certain diseases have a selective effect in increasing the need for one particular nutrient: the most striking example is the huge increase in protein break-down that occurs following burns and other trauma, necessitating a correspondingly high protein intake. In other diseases, such as diabetes, nephritis, and peptic ulcer, it is necessary to modify the normal diet, although from a purely nutritional standpoint such modifications are often undesirable. In the latter instance, it is the responsibility of the medical attendants in charge of the case to ensure that the patient's essential nutrients are somehow being supplied in a form which that particular patient can utilize. The diet of any invalid is not a new combination of foodstuffs, but simply a normal diet modified if necessary to fit the extra needs or individual limitations.

The essentials of such a diet may be stated in quantities of calories, protein, minerals, and vitamins; or, more intelligibly perhaps, in terms of common foods. Canada's Food Rules are an excellent yardstick, and one that is readily available. These are given in the accompanying table. For patients not requiring special diets, they serve as a useful guide in prepar-

Canada's Food Rules

These are the foods for health. Eat them every day.

Drink plenty of water.

1. *Milk*—Adults, ½ to 1 pint. Children 1½ pints to 1 quart.
2. *Fruit*—One serving of citrus fruit or tomatoes or their juices; and one serving of other fruit.
3. *Vegetables*—At least one serving of potatoes; at least two servings of other vegetables, preferably leafy, green, or yellow, and frequently raw.
4. *Cereals and Bread*—One serving of a whole-grain cereal and at least four slices of Canada Approved Vitamin B bread (whole-wheat, brown, or white), with butter.
5. *Meat and Fish*—One serving of meat, fish, poultry or meat alternates such as beans, peas, nuts, eggs, or cheese. Also use eggs and cheese at least three times a week each, and liver frequently.

A fish liver oil, as a source of vitamin D, should be given to children and expectant mothers, and may be advisable for other adults.

Iodized salt is recommended.

ing meals. But any person who has tried to feed a fretful, uninterested chronic invalid, with no appetite, will feel that such theorizing is of little value in the face of firm refusal to eat. In fact, most of the patients requiring bedside nursing are either unable or unwilling to take a full diet. The main types may be divided roughly as follows: acute febrile illness; chronic febrile illness; chronic non-febrile illness; fractures, burns, and postoperative cases; postpartum patients. The special problems involved will be considered under these separate headings.

Acute Febrile Illness

As mentioned previously, fever hastens the utilization of food-stuffs in the body, so that all the nutritional needs are increased. In addition, it is believed that ascorbic acid (vitamin C) combines with sulfonamides, so that it is not completely available for its normal bodily functions. Thus, in many cases, the need for ascorbic acid is disproportionately increased. Since most of these patients require a liquid diet, it is not always possible to supply optimal amounts of all the nutrients orally. Fortunately, the body stores of most of the essentials are sufficient to make up for dietary lacks for a short time. A liquid diet should be as high as possible in calories and ascorbic acid; it should be realized that such a diet is not completely adequate and that it should be given only for a minimum of time. The use of fruit drinks with added sugar, particularly the citrus fruits, supplies both calories and ascorbic acid. Since it is important that the liquid intake be large, the use of salt is advantageous, both as a stimulant to thirst and to prevent salt depletion. This can be given in broth or tomato juice; the latter has the added advantage of a high ascorbic acid content. As soon as possible milk should be added to the diet to supply protein.

Chronic Febrile Illness

The normal, well-nourished individual has sufficient minerals and vitamins "stored" in the body to maintain adequate function for some weeks, even on a very poor diet. However, in a prolonged illness, such as tuberculosis, with hastened destruction of nutrients due to fever, proper nutrition is of paramount importance. Although the old idea of "fattening up" tuberculous patients to the maximum is no longer in vogue, a high caloric diet, rich in all the protective foods, is very important. All too often adequate supplies of fruit juices are available in hospitals only to patients on liquid diets; in a full diet, ascorbic acid is supposed to be supplied largely from vegetables. But vegetables cooked in large quantities and kept hot for some time before serving have a very low ascorbic acid content when eaten. Ample supplies of orange, grapefruit or tomato juice should be provided daily for all patients, as well as plenty of well-cooked vegetables, and raw native fruits in season. Commercial fruit juice concentrates frequently have a low vitamin C content and should be used with caution.

Bed patients need plenty of protein, and frequently lack appetite for large amounts of meat. Milk is a valuable and economical source of protein, and should be given in ample quantities.

It is not possible to give a person with only average appetite large amounts of protective foods unless the non-protective foods are correspondingly decreased. The use of cake, pastry, and other sweets, refined cereals, and soft drinks should be discouraged so that the patient has appetite for meat, milk, vegetables, fruits, and whole-grain cereals.

Chronic Afebrile Illness

These are mostly elderly patients, with capricious appetites and long-established food habits which they are unwilling to change. No more obstinate problem confronts the nurse than that of feeding such patients adequately. Bulky foods and very fatty or

fried foods should be avoided, since they impair appetite and may cause flatulence. The edentulous patient may find it impossible to chew meat; if even finely minced meat cannot be taken, a high milk intake is indicated to supply protein. The food should, of course, be well cooked and attractively served. If it is well salted, it will be more palatable to most patients and the salt tends to stimulate appetite.

Postpartum Patients

The aim with these patients is simply to furnish an ample diet, high in protective foods, and adequate fluids so that lactation will be successful. Many mothers seem to have been "oversold" on the importance of milk, and it is not unusual to find one who is taking two or three quarts of milk a day, and very little else. It is important that such women should be instructed about a properly balanced diet, with moderate amounts of milk and other fluids, and a good supply of *all* the protective foods.

Fractures, Burns, and Postoperative Cases

In recent years it has been demonstrated that there is extensive breakdown of protein following any trauma; this is most notable in the case of burns, but also occurs after other injuries, including surgical operations. Because of this destruction of protein, the body stores are much depleted unless a large amount of protein is administered. For this purpose, blood and plasma transfusions and, more recently, preparations of amino-acids for intravenous use, have become an important factor in care of surgical patients. There is no advantage in giving protein intravenously instead of by mouth; if the patient is able to take it by mouth, it is the preferable route. It was hoped that concentrated preparations of amino-acids, taken by mouth, could be used to give a high protein intake. However, the nauseous flavor of such preparations makes them unsuitable, and present opinion is that food proteins taken by mouth are preferable. In the invalid dietary, the most important source of protein is milk and the amount of natural protein in milk may be greatly augmented by adding casein or egg. "High-protein milk" may advantageously be given as early as possible, in large quantities, to surgical patients.

Ascorbic acid is believed to be a factor in wound-healing; in scurvy, wounds will not heal. There is some evidence in animal research that ascorbic acid is used up with abnormal rapidity after fractures. It is, therefore, advisable to give ample supplies of citrus fruit juices to surgical patients.

Nutrition Education

In looking after the feeding of patients, the nurse has an excellent opportunity for nutrition education. Such education is often difficult when people are well. The attitude of "My father didn't have more than six oranges in his whole life, and lived to be ninety. What was good enough for him is good enough for me" is frequently voiced, or thought. In illness, some of this assurance drops away: obviously, at the moment, the patient is not proving his ability to look after himself without assistance. He may be more receptive at this time to ideas about improved food habits. Such ideas need not always be expressed, since the best education is done by example rather than lecturing. By being introduced, perhaps for the first time in his life, to properly prepared, nourishing foods, at a time associated in his mind with recovery from illness, the patient may acquire an augmented respect for the importance of nutrition or, more probably, simply a liking for a well-balanced meal.

Before relinquishing care of her patient, the nurse can perform a useful service by giving him some advice about his ordinary diet. While this is essential with patients on special diets, it is seldom done for others, who often are surprisingly ignorant of nutritional requirements.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Up in the Air with Patients

M. E. GLEADOW

SASKATCHEWAN operates the only exclusive Air Ambulance Service of its kind on the continent. As nurse for the service, I should like to tell you, informally, about some of the more interesting features of my work.

You are probably aware that the only patients we carry are emergency cases. As a result, the Air Ambulance nurse is quite a busy person while in flight. The relative accompanying the patient usually requires more attention than the patient himself. His concern for the loved one, combined with the nervous condition on a first flight, often make him deathly air-sick. Don't let me frighten you, however, as a person is rarely air-sick unless he is in very low spirits.

Picking up a patient — *Saskatchewan Film Board Photo*

Putting the patient aboard *Saskatchewan Film Board Photo*

Most of our patients are taken to the larger cities in the province, but in some cases the smaller town hospitals have to be utilized.

The polio epidemic caused considerable work last autumn, and we transported many of these patients. During the summer months, the greater part of our work comprises accident cases, which require constant attention while in the air.

The nature of the work is rather exciting due to some element of hazard. Mind you, it's not as bad as many people would imagine. Many frown on aircraft and fear this type of travel. However, it seems that day after day we carry people who have been hurt in accidents, but somehow we just never meet anyone who has been hurt in an aeroplane. It is admitted, however, that we do get some pretty rough rides landing in some hilly fields.

Every day we experience something new. If you are interested, I should like to tell you of some experiences. One summer day when thunder-storms prevailed, we were between two of the western cities at a nice altitude when a thunderhead was spotted on the horizon. Course was changed to go around it, but just as we were passing it the winds caught us. It seemed that we were going up one hundred miles an hour and down the same speed at the same time.

On another trip, the usual excited waving of the farmer was spotted and a landing in some very rough country was made. I jumped out with my hot water bottles and set out for the farmhouse. A young man met me half-way, and to my query "Where is the patient?", he replied, "There is none here." "Well, why did you wave?" I asked. "Oh, I always wave at aeroplanes," he replied.

We took off from there and went further into the hills where we spotted some people standing around a burning haystack, waving frantically. The field in which we

landed bore a marked resemblance to the Rocky Mountains. Again I enquired the whereabouts of the patient. A man stepped forward to tell us the patient, his brother, lived in the valley some miles away. He thought we would not be able to locate the patient's home, and so had lighted the signal fire at his own place!!! He insisted on accompanying us as "guide," but ten feet off the ground he was completely lost.

We have made two trips into the United States, and anticipate more to convey special cases to various points where specialized attention can be given — places such as the Mayo Clinic at Rochester.

The nurse's equipment consists of a doctor's kit, with the necessary instruments and dressings, stimulants, morphine, sickness cups, bed-pan, etc. A supply of drinking water is also carried at all times.

All I have told you has been the rougher side of my duties as an Air Ambulance nurse, but this work has its good points. There is an intense satisfaction experienced when seriously ill patients have been safely transported to adequate medical attention.

To say the least, the work of an Air Ambulance nurse is anything but routine and I can say without reservation that it is a most interesting and enjoyable position to hold.

Air Ambulance Service

On February 3, 1947, the Saskatchewan Government's Air Ambulance Service celebrated the anniversary of its first year of operation in the midst of the worst snow conditions in years, which resulted in a record monthly total of seventy-eight "mercy flights" during January. Carrying patients ranging in age from new-born infants to grandparents of more than ninety years, the southern section of the service had made 257 flights, had carried considerably more than that number of patients, and had flown about a hundred thousand air miles up to January 30. Its facilities had grown from one plane and three crew members to the present two planes and ten staff members.

Meanwhile, the northern section of the service, operated by planes of the Natural Resources Department largely north of Prince Albert, had completed forty-two flights and had carried about seventy patients. Thus, total flights, north and south, numbered 299 and the number of patients carried greatly exceeded this figure.

The inauguration of the service was typical of its subsequent operations. It was planned to get under way on February 4, 1946. But on February 2 most of the province's roads were blocked by a blizzard. An emergency call came in on Sunday, February 3, and the air ambulance service made its first historic flight. Ever since that time it has been conducting an unending battle against illness, death, time, and weather. The measure of its success is partially recorded in the books. But, more poignantly, it is recorded in the hearts of patients whose lives have been saved or recoveries speeded and in the grateful hearts of relatives and friends.

Born in the mind of a returned wartime flier, and leaning on the experience of a humanitarian Regina ambulance service operator, who conducted a similar service on a smaller scale before the war at considerable loss to himself, the idea of a government-operated air ambulance has developed into a service which commands the highest regard in Saskatchewan and which has gained fame throughout the continent.

Types of cases vary widely and there are about fifty different diseases and accidents on record. Acute appendicitis cases, chronic illnesses, such as heart disease, maternity cases, and farm accident cases rank high in the percentage of patients carried. During the polio epidemic last fall, a large number of children were flown to the polio clinic at Saskatoon.

One of the two registered nurses goes along on every flight to look after the well-being of the patient. Usually only one patient is carried but up to three, two stretcher and one walking case, have been carried on occasion.

Although 257 flights were made, total number of calls received numbered over four hundred. Even allowing for trips on which

more than one patient was carried, this leaves a number of calls which could not be answered because of weather, terrain, light, or other conditions. Many night calls could not be answered because regulations prohibit night flights to any except lighted landing fields.

Calls for the air ambulance are usually made by doctors although, when no doctor is available, calls may come from a nurse or a municipal or other official. Quite often a call comes from a doctor who has not been able to visit the patient, but to whom the patient's condition has been described over the telephone.

For all emergency flights within the province, only a nominal fee of twenty-five dollars is charged the patient, no matter what the distance, although this does not begin to pay the actual operating expenses for even the shortest trip. The provincial government pays the large deficit in operating costs. So far, the co-operation of doctors and the general public in calling the air ambulance only for genuine emergencies has been very good.

Radioactive Isotopes

One of the first peacetime uses to which biproducts of the atomic energy facilities have been put is in the production of "isotopes," tiny radioactive fragments weighing only about one-ten thousandth of an ounce. For the next 10,000 to 25,000 years these pea-sized units of Carbon 14 will emit 37 million beta particles per second and will be used in research in connection with such studies as: mechanisms by which cancer is produced; dysfunction of the thyroid glands; growth and composition of teeth and bones; utilization of sugar in diabetes; utilization of all essential food components; the turnover of iron in anemic conditions; problems associated with radioactive isotopes themselves.

Scientists contemplate the use of isotopes in two important ways: First, as tracer atoms or "tracers" for following the course of atoms in chemical, biological, and technical processes, and, secondly, as possible therapeutic agents for treatment of certain special diseases. The value of radioisotopes, however, is considered to reside more in the study of the causes of disease than in treatment.

Each atomic element may occur in "sister" forms, called isotopes. An isotope differs from its sisters in the structure of the atomic "heart" or nucleus. The satellite electrons around the nucleus are arrayed the same for each element, hence the "sisters" meet the outside world and behave chemically alike. In addition to the stable sisters of elements which may occur in nature, it is possible by man-made devices, such as a pile or other atomic nucleus bombarding devices, to make isotopes which do not occur in nature and which are radioactive.

Radioactive sisters behave chemically the same as their normal stable sisters. Because of their radioactivity, however, they can be followed in the processes in which they participate. Various terms have been used to indicate this property by which radioactive sisters can be followed, such as "tracer," "labelled," or "tagged" elements. By this it is meant they can be tagged much as wild fowl are banded to follow their migration. The tracer application is often also explained by an analogy with the use of tracer bullets. A tracer bullet follows the same path and arrives at the same target as a normal bullet but can be seen by the visible radiation which it emits. In the case of a tracer element or tracer isotope, it is "seen" by instruments, such as Geiger counters or electroscopes, which receive and register the radiations emitted by the radioactive atomic "hearts."

Very small organisms or very small virus particles can be followed by highpowered microscopes or by electron microscopes. The tracer element technique permits an even more minute and detailed investigation of chemical and biological processes. In this case, atoms and molecules themselves may be traced and, furthermore, their identity and changes in identity may be followed. This amounts to an "atomic microscope."

In a few cases the tracer bullet isotopes are not only useful as tracer or "atomic spies" but as active "atomic artillery"; in which case the radioactive isotope can be used to irradiate the locations where they deposit. Some influence has been thus achieved in controlling certain forms of leukemia, and polycythemia vera, both very special types of blood disorders. The use of radioactive materials in therapeutic connections is still very much in the investigational stage.

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INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Cost Analysis of a School of Nursing

ELVA HONEY *and* LOUISE BARTSCH

SCIENTIFIC management in the hospital field is recognized as an important administrative factor. The present crisis in hospitals, due to shortage of staff and constant increase in prices, has stimulated the thinking of hospital administrators along the lines of cost analysis of all departments of the hospital, including the nursing department through which nursing service is provided. The cost analysis in a hospital conducting a school of nursing is complicated by the fact that the nursing department includes both nursing service and nursing education.

Superintendents of nurses have long been interested in making a study of the cost of the school of nursing. However, without the knowledge of the costs of other departments in the hospital it has been impossible for them to estimate the amount spent by the hospital on the school of nursing.

It is apparent that a cost study of an independent school is a much simpler matter than determining the cost of a school of nursing administrated by a hospital to which it has a service obligation. The items of expense of independent schools should serve as a guide in determining the costs in schools of nursing conducted by hospitals which are striving to improve professional standards. Therefore, in attempting the more difficult process of analyzing the cost of a school of nursing administered by a hospital the following brief outline, in terms of basic considerations and general procedures, is presented as a guide in undertaking such a study.

BASIC CONSIDERATIONS

1. It is a sound business practice for the hospital to determine the cost of all departments within its organization.

2. The superintendent of nurses can assist in determining the cost of the nursing department, which is made up of: (a) the cost of nursing service; (b) the cost of nursing education.

3. Budget planning will be possible after the above factors have been determined.

STEPS IN PROCEDURE

One would expect that if the cost of nursing service were subtracted from the total cost of maintaining the nursing department, the result would give the cost of nursing education, but students, while being educated, give some nursing service. Therefore, to determine the cost of nursing education properly we must further subtract the nursing service value that the students contribute in the whole pattern of nursing service.

To arrive at the value of student nursing service we have to decide the proportionate worth of students to graduates. This will vary in each hospital and can only be obtained by doing time-studies of their activities.

DETAILED ANALYSIS OF COSTS

Mixed Staff	All Graduate Staff
Direct Costs (variable)	Direct Costs (variable)
1. Salaries of instructors 2. " of librarian 3. " of office personnel employed exclusively in school of nursing 4. Classroom expenses 5. Library 6. School calendar and other office supplies 7. Textbooks, uniforms, etc. 8. Entertainment and recreation 9. Affiliation expenses 10. Graduation 11. Part salaries of administrators, supervisors, and head nurses 12. Subsidiary workers 13. Health service and pensions 14. Miscellaneous	1. Salaries of general staff nurses 2. " of administrators 3. " of head nurses and supervisors 4. Recreation 5. Library. 6. Office personnel 7. Office supplies 8. Facilities for in-service education 9. Subsidiary workers 10. Health service and pensions 11. Miscellaneous
Indirect Costs (fixed)	Indirect Costs (fixed)
1. Administrative costs 2. Meals 3. Laundry 4. Plant operation (school and residence) 5. Maintenance and repairs 6. Depreciation and insurance 7. Residence personnel 8. Telephones 9. Miscellaneous	1. Administrative costs 2. Meals 3. Laundry 4. Plant operation (residence) 5. Maintenance and repairs 6. Depreciation and insurance 7. Residence personnel 8. Telephones 9. Miscellaneous
Total cost	Total Cost

The Massachusetts General Hospital, for example, estimated the student to be three-quarters the value of the graduate (1932). Dr. Louis Block, in his study for the United States Public Health Service, discovered that this value ranged from 0.4 to 0.9 (1946). The financial value of student nursing service should then be estimated on the basis of the total salaries paid the number of graduates necessary to replace them. It should be kept in mind, however, that, because of classes, the students do not give as many hours of nursing service per day as graduates would; also that affiliation takes the students out of the service for considerable lengths of time. However, in some situations, these students are replaced by students affiliating from other schools.

When the cost of nursing education

to the hospital has been determined, the superintendent of nurses then wants to know the cost of an all-graduate staff in comparison with the cost of the mixed staff of the school of nursing, so that she may know whether the students are receiving more or less than they are giving. The technique used to determine these costs is to list: (1) the full cost of the school; and (2) the full cost of graduate staff necessary to replace the students. These costs should be computed on a one-year basis as this is the smallest unit of time which can give an accurate picture. The accompanying table indicates the major items which should be considered in this study.

Conclusions and Deductions

1. The difference between these costs, that is, mixed versus all-graduate staffs, will show whether the school is an asset or liability to the hospital.
2. If the school is a marked asset to the hospital the students obviously are giving more than they are receiving.
3. The superintendent of nurses is then justified in asking the hospital to allocate more to the school.
4. If the school is costing more than an all-graduate staff, it would be *financially* advantageous for the hospital to discontinue it. However, for such reasons as prestige or interest in education, it may be desirable to continue the school. At this point, the question of students' fees, as are charged in all professional schools, could be considered.

On the basis of this cost analysis the superintendent of nurses is in a position to plan a budget which will ensure maximum educational benefits for the school.

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Coming Events

Registered Nurses' Association of Nova Scotia

Event: Annual meeting.
Date: June 11 and 12, 1947.
Place: Halifax, N.S.

Association of Nurses of the Province of Quebec

Event: Twenty-seventh annual meeting.
Date: May 26 and 27, 1947.
Place: Windsor Hotel, Montreal, P.Q.
Special note: English program: Panel Discussion on "Labor Legislation as it Affects Nurses." French program: Address on "The Profession." Forum on Industrial Nursing.

Saskatchewan Registered Nurses' Association

Event: Thirtieth annual meeting.
Date: May 29 and 30, 1947.
Place: Hotel Saskatchewan, Regina.

Planned Operating-Room Experience for the Student Nurse

CAROL M. ADAMS

THERE has been much discussion as to the value of operating-room experience for student nurses. Advantages a student derives from a carefully planned and well-guided experience are:

1. Develops self-confidence through a broadened outlook.
2. Increases skills.
3. Stimulates interest and enthusiasm.
4. Gives a better understanding of the different types of operative procedure and their relation to the patient's safety and progress.
5. Develops an appreciation of the scientific basis for aseptic operative technique, and the application to nursing procedures in general.

Several requirements are necessary for a well-planned teaching program in this department. Within the operating-room, work is done as a group—without co-operation and co-ordination all is lost. How can this group activity be made a happy and satisfying experience for all? One requirement is a well prepared leader who has the ability to stimulate enthusiasm, is blessed with physical and mental health, a good sense of humor, and with a confirmed habit of thoughtful consideration of people as persons, people as individuals. Constantly working with nurses, students, and graduates at different levels of development requires the confidence of everyone with whom she comes in contact. Ordway Tead, in his article "How to Improve Personal Supervision," says: "The most successful supervisor is on the whole the one who is most a person. The bigger the person, the better the supervisor. By a big person we mean one who has a rich nature, warm feelings, broad ideas, and a hearty eagerness for life as a whole."

Plans, policies, and procedures need to be discussed, and free exchange of ideas and participation encouraged. Much is gained from a variety of shared interests. This, in turn, promotes activity that ensures progress and stimulates growth of the group so that they become a vital part of the whole. Group decisions must be the prominent feature of a democratic unit.

A well-planned, flexible, and progressive program is essential, with good clinical experience. Operating-room experience given in the early part of the second year has proven of exceptional value in developing nursing abilities. The knowledge and skills learned in the operating-room supplement and strengthen the student nurse's future experiences. An effective teaching program, providing for progressively increased difficulty and responsibility, can be carried out during an eight-week period, giving a varied and graduated experience. It is important that this experience be undisturbed and undivided to give the maximum results.

The organization and planning of a teaching program will of necessity vary according to the facilities, activities, and personnel in the operating-room. A program such as is here outlined has proven satisfactory and may be adapted to various situations.

During the month preceding operating-room experience, each nurse attends an eight-hour course of lectures on such topics as anesthesia, sterilization, preparation of supplies used in the operating-room, manufacturing and care of sutures and instruments, various positions of patients, and preparation of the hands. A final examination is given and is discussed with the class.

A two-week rotation plan is strictly followed, making organized teaching in the operating-room possible. During the first two weeks' experience,

daily classes given at the beginning of the day are arranged for the new students. The head nurses alternate each two weeks in giving this instruction. The orientation program is carried on throughout the entire eight-week period.

A definite program is planned for the new students the first day. At the initial orientation conference, each student is introduced to the physical set-up of the operating-room, to her special duties as a junior student, to special routines, techniques and procedures. This helps the student to fit into and feel a part of the operating-room organization. Each student is given a manual at the beginning of her experience which is used as a teaching aid and reference. In the manual are instructions pertaining to operating-room routines and suggestions for the solution of problems that commonly arise. The manual also contains each day's list of topics and procedures to be discussed and demonstrated by the head nurse, followed by questions, with space left for the nurse to fill in the answers. The following is a sample of the first day's work in the manual:

FIRST DAY DUTIES

Topics to be included in class discussion, demonstration, and practice periods:

(a) Names of the members of the operating-room staff.

(b) Number and location of each room in the operating-room suite.

(c) Equipment in general for a completely furnished room, not including instruments.

(d) Location of sterile linen, gloves, catgut, etc.

(e) Location of fire extinguishers.

(f) The immediate pre-operative and post-operative care of the patient in the operating-room.

(g) Adjusting of overhead lights and spot lights.

(h) Adjusting operating-room tables and positions of patient for various operations.

(i) The anesthetic table and care of equipment.

QUESTIONS AND EXERCISES

1. Describe fully the preparation of the patient in the anesthetic room before operation.

2. Describe fully the care of the patient when operation is completed, and before patient is returned to the ward.

3. Discuss the importance of good housekeeping in the operating-room.

4. Sterilizers: (a) Rules for operating high pressure autoclave; (b) rules for operating water-tank.

5. Care of anesthetic equipment—duties performed after equipment is used: (1) Magill tubes; (2) rubber airways; (3) anesthetic table; (4) mask and tubing belonging to the machine; (5) laryngoscope; (6) metal ether mask.

6. Miscellaneous specific observations made from the students' stand. List at least eight, (e.g., noted that circulating nurse never allowed discarded sponges, pieces of paper, etc., to lie on the floor).

Each manual is carefully checked by the head nurse daily and the student is given an opportunity to discuss any point that does not seem to be clear. This method of teaching is uniform and standard, enabling each head nurse to be familiar with what is taught and making it easier for her to carry out the necessary follow-up and guidance which is so valuable for each student. Following the orientation conference each student observes an operation from a viewing-stand and, again, is expected to write down eight specific observations made, noting especially the various procedures in which the nurses are engaged. Confidence is gained and a better picture of the whole situation is obtained from this observation period.

At the end of the first two weeks, class instruction is given on the duties and the procedures to be carried out by the junior scrub nurse. A review of sutures, draping, and instruction on sponges and assisting the senior scrub nurse is presented. The group is also taught how to completely set up the operating-room with sterile supplies.

A discussion of the value of Lane's or bone technique, and demonstration of its use is given to the group at the end of the third week's experience.

Before starting the fifth week's experience a demonstration of senior

scrubbing is given. To make an operation realistic to the students, a mock operation is undertaken. Draping is applied, and the instrument table placed over the imaginary patient. Assignment as senior scrub nurse is made for each pupil in turn, following demonstration by the instructor. Other members of the group act as surgeon and assistant surgeon. Deftness in handing instruments and sutures to the surgeon is co-ordinated with alacrity in thinking.

The seventh and eighth weeks in the operating-room incorporate the senior duties, and the class preceding this term stresses the importance of taking responsibilities, maintaining standards, and assisting in teaching and guiding the oncoming students.

A select library in the operating-room, with a few well chosen references, is of inestimable value to both student nurses and graduates. Alexander's "Operating Room Technique" has proven especially helpful and "Atlas of Surgical Operations," by Cutler and Zollinger, although written for the interne, is very useful.

Continuous development requires constant guidance and supervision, as individuals differ in mental and physical capacities and reactions. That the student may evaluate her own progress, a conference is held with her at the end of the first month, discussing her strengths and where she needs further strengthening, giving specific suggestions and examples characteristic of her work. Greater progress can thus be made before the student is finally evaluated at the termination of her operating-room experience.

A program such as is described above may seem complicated and not adaptable to a small school, but it is practical and, if started in a small way, may be built up and added to when possible. The unity that results from working together prevents friction, unhappiness, and dissatisfaction, and a staff that co-operates for a common goal accomplishes its work with a minimum of effort, time, and discontent.

Consultation Vans for Infants

One of the most serious consequences of the long period of restriction imposed on France by the war and occupation was the increase of infant mortality throughout the country. The French Red Cross is considering, in agreement with the Ministry of Health, a scheme of consultation vans which would travel through the communes and reach the rural population where the evil is just as serious as in the towns and more difficult to relieve. The medical and social services are short of staff and means of transport and can reach the infants in the rural districts but too rarely.

The war material of the French Red Cross was reduced and worn out by so much exhausting work; it has been renewed, thanks to the allied Red Crosses, and although it is now of uneven quality it is nevertheless possible to continue the work. The first formula consisted in using large lorries given by the American Red Cross. These lorries are now being arranged and divided into two compartments for use as consultation rooms.

The first compartment has a bench, three folding cots, two lavatories with wash-basins, a paraffin stove with three burners for heating the room and the water, and a scale for weighing babies. Some lorries also have an extensible chair for prenatal examination. The infant is undressed, washed, and weighed in this room in preparation for the second compartment which is the doctor's consultation room with all the necessary fittings.

These cars are placed at the disposal of the departments; the costs are provided by the public health and social welfare services. They are driven by Red Cross women drivers who have received a medico-social training enabling them to give efficient help to the doctor and his staff during the consultations.

This service may be considered as a very valuable contribution to the maternity and child welfare work in rural districts in France. It is hoped that it will become largely generalized, particularly in the most sparsely populated areas.

— *League of Red Cross Societies.*

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Aide ou Auxiliaire en Manitoba

FRANCES WAUGH

JE VEUX vous transmettre des renseignements que je vous apporte du Manitoba sur la licence et la préparation de l'aide ou auxiliaire. Je diviserai mon travail en quatre points: l'histoire, la loi, notre expérience, et le diagnostique.

L'histoire: Quand le registre des médecins et des infirmières, l'ancien registre des infirmières de Winnipeg, fut réorganisé en 1921, des auxiliaires ou aides, ayant reçu au moins six mois d'entraînement, furent enrollées sur le registre pour faire du service à domicile. Quelques-unes d'entre elles avaient suivi un cours dans les sanatoria, d'autres étaient diplômées d'une maternité ou d'un hôpital d'aliénés, et d'autres avaient quitté l'école d'infirmières avant d'avoir terminé leur cours. La registraire leur donna des cas selon leur compétence et elles reçurent une rémunération qui fut déterminée par le comité de direction du registre.

Au début de 1944, une délégation de ces aides rencontra le comité de direction du registre et demanda à être payées 35 cents de l'heure au lieu de 25 cents, disant qu'il y avait des personnes n'ayant aucun entraînement et très peu d'expérience qui recevaient plus que celles inscrites au registre. La révélation de ce fait décida les auxiliaires à tenter d'évaluer les services qu'elles rendaient et elles en vinrent à la conclusion qu'il fallait qu'elles aient un programme d'entraînement et des règlements pour leur travail. La première chose qu'elles firent fut d'organiser l'Association des Aides (practical nurse). Elles demandèrent l'assistance d'autres groupes, union ouvrière, et l'Association des Infirmières Enregistrées du Manitoba.

L'Association des Infirmières Enregistrées conseilla aux aides de demander au Ministère de la Santé et du Bien-Etre de présenter une loi les concernant et de préparer un mémoire pour le ministre. Ce conseil fut accepté par les aides et une délégation se présenta au Sous-Ministre de la Santé.

La demande des aides fut bien accueillie par le Ministère de la Santé et du Bien-Etre. Un comité fut nommé immédiatement pour préparer un projet de loi.

Ce comité était composé d'un représentant de l'Association des Hôpitaux du Manitoba, de la Société Médicale du Manitoba, de deux membres de l'Association des G.M.E., de deux de l'Association des Aides.

Plusieurs lois furent présentées comme exemple. Le projet final fut préparé par un comité de législation. Un mémoire fut préparé et présenté au parlement avec le projet de loi. Voici quelques points importants de ce mémoire:

1. Quelque soit la fortune d'un malade, les soins d'une infimière doivent lui être donnés lorsqu'il en a besoin.

2. Lorsqu'on analyse les services rendus aux malades l'on constate que certains d'entre eux peuvent être rendus par une aide sans qu'il y ait danger pour le patient.

3. Le but de cette loi n'est pas d'enlever aux auxiliaires leurs moyens d'existence, mais plutôt de les mettre en mesure de rendre service là où elles peuvent le faire.

Le ministère en recommandant cette loi avait en vue de:

1. Donner à l'aide qualifiée un status légal reconnaissant par là les services qu'elle rend et du fait protéger ses intérêts en empêchant la concurrence de personnes non qualifiées soignant les malades pour un salaire.

2. Mettre à la disposition du malade, lorsqu'une infirmière professionnelle n'est plus nécessaire, mais qui ne peut être laissé entre les mains d'une personne incompétente, une personne qualifiée capable de rendre service.

3. Permettre à une personne d'executer le travail, qui demande moins de compétence mais prend beaucoup de temps, dans les soins à donner aux convalescents, aux malades chroniques dans les institutions ou à domicile, et ainsi permettre aux infirmières professionnelles de consacrer tout leur temps aux gravement malades.

La loi fut sanctionnée le 23 mars 1945. Elle est administrée par:

1. Un conseil composé comme suit: Président, nommé par le ministre; 1 membre, nommé par le Bureau des Gouverneurs de l'Université du Manitoba; 2 membres, nommés par l'Association des Infirmières Enregistrées du Manitoba, l'une d'elles doit être une institutrice; 1 membre, nommé par le Conseil des Hôpitaux; 2 membres, nommés par l'Association des Hôpitaux du Manitoba; 3 membres, nommés par l'Association des Aides (practical nurse). Membres ex-officio: Le Sous-Ministre de la Santé, la directrice des Infirmières Hygiénistes Provinciales, la régistraire et conseillère des aides.

2. Un bureau de direction formé par sept membres du conseil dont les devoirs sont déterminés par la loi.

3. Des comités spéciaux ont dû être nommés pour faciliter l'administration de la loi, les voici:

(a) Le comité du programme d'étude qui est chargé de préparer le programme d'étude pour les aides. Ces mêmes personnes font aussi partie du comité des examinateurs chargé de corriger les examens et de marquer les points.

(b) Le comité de créance formé de quatre membres étudiant toutes les demandes de licence; ce comité continuera à examiner les qualifications des aides demandant le droit de pratique par réciprocité et les qualifications des personnes désirant suivre le cours.

4. La nomination d'une régistraire et consultante, une infirmière enregistrée, dont les devoirs sont:

(a) Recevoir toutes celles qui demandent une licence pour exercer comme aide licenciée et examiner les qualifications de chacune.

(b) Ménager des entrevues aux aides et les aviser.

(c) Surveiller le cours de toutes les aides dans la province.

(d) Tenir un registre de toutes les aides de la province.

5. Avec l'approbation du ministère établir une école centrale pour la formation des élèves. La partie théorique du cours, institutrices, matériel d'enseignement, seraient à la charge du ministère et l'expérience clinique serait fourni par les hôpitaux.

6. Avec l'approbation du ministre, faire avec une institution, les arrangements nécessaires pour l'entrainement au complet des aides.

Expérience: A l'une des premières assemblées du comité des aviseurs, l'Association des Hôpitaux du Manitoba et l'Association des Aides recommendèrent l'adoption d'un tarif suivant, qui fut approuvé par un ordre en conseil:

8 heures de service, $3.60;10 heures de service, $4.00; 4 heures de service le soir, $2.00; temps supplémentaire, 45 cents de l'heure.

Les auxiliaires furent averties par différents moyens de publicité qu'elles devaient se procurer une licence avant le 31 décembre 1946 si elles voulaient être acceptées sous la clause d'exemption (waiver clause).

Pour obtenir leur licence elles doivent remplir une formule donnant diverses informations, entre autres, l'institution où elles ont reçu leur formation ou acquis de l'expérience, le nom d'un médecin et d'une infirmière professionnelle pouvant témoigner de leur compétence. Une entrevue avec la régistraire est aussi nécessaire. Si les renseignements sont satisfaisants et approuvés par le comité de créance et le conseil, l'aide reçoit une licence puis une carte d'identification et une épingle qui

doivent être renouvelés annuellement.

La licence est de cinq dollars et son renouvellement annuel un dollar. Deux cours de perfectionnement furent donnés en 1946 pour les personnes qui n'avaient pas les qualifications nécessaires. Des stages dans les hôpitaux durent être faits par quelques-unes qui avaient besoin de plus d'expérience.

Les six cents personnes que j'ai vu à mon bureau peuvent se classifier comme suit:

(a) Très peu d'expérience, aucune instruction; (b) plusieurs années d'expérience, aucune instruction; (c) n'ayant suivi que le cours de l'Ambulance St-Jean ou de La Croix-Rouge; (d) des vétérans ayant eu de l'expérience dans les hôpitaux; (e) des diplômées de maternité, d'hôpitaux d'aliénés ou de sanatoria; (f) des élèves n'ayant pas terminé leur cours d'infirmière; (g) des infirmières diplômées non-enregistrées.

Environ quarante suivirent les cours de perfectionnement. A date 418 ont reçu une licence. L'on conseilla à celles qui furent refusées de suivre le cours en entier. Le règlement concernant le travail des aides a été préparé mais n'est pas encore officiel.

En janvier 1946, les premières classes, conformément aux dispositions de la loi, furent acceptées. L'une, à l'école centrale, trois petits hôpitaux (n'ayant pas d'école d'infirmières) donnèrent l'expérience clinique. Une infirmière en hygiène publique fut nommée institutrice; elle fut aidée par la diététicienne du Ministère de la Santé. L'autre classe fut acceptée au Sanatorium de St-Boniface, affiliation avec l'Hôpital Ste-Rose.

Le cours consiste en trois mois de théorie et neuf mois d'expérience clinique. A date l'expérience n'est donnée que dans les hôpitaux et sanatoria. Nous espérons sous peu être en mesure de donner aux aides une expérience à domicile. Voici ce qui est exigé pour l'admission au cours d'aide:

(a) Le 8e année du cours d'étude; (b) un certificat de bonne santé; (c) si l'étudiante n'a pas 21 ans lorsqu'elle termine son cours, elle ne reçoit pas sa licence avant d'être majeure; durant cet intervalle elle doit être sous la surveillance immédiate d'une infirmière enregistrée.

Depuis l'ouverture de la première classe, l'école centrale dirige des cours pour six hôpitaux; quatre institutions ont leurs propres écoles.

Une enquête faite en décembre révélait qu'il manquait 250 aides dans les institutions. Une lettre a été adressée à toutes les institutions d'hospitalisation, les avisant que les personnes n'ayant pas de licence ne peuvent être employées que comme bonne ou aide de salle, et jusqu'à nouvel avis de la règlementation du travail, la directrice du personnel ne devait leur confier que le travail qu'elles peuvent accomplir.

Diagnostic: D'après mon expérience de l'an dernier je désirerais:

1. Que toutes les auxiliaires qui demandent une licence et qui n'ont jamais reçu d'entraînement (a) passent un examen; (b) qu'elles aient quatre ans d'expérience.

2. Qu'on se rappelle, qu'un des buts de la loi est de placer l'aide selon sa compétence, nous devons examiner avec soin tout le travail de l'infirmière afin de déterminer ce qui convient aux aides. Dans notre province nous n'avons pas suffisamment de personnel dans les campagnes pour soigner les malades. Nos étudiantes ne sont pas préparées pour faire du travail d'hygiéniste. Nous ne voulons donc pas, à moins que ce soit à titre d'expérience, placer nos aides dans les unités sanitaires du moins jusqu'à ce que l'organisation et la surveillance du service auprès des malades dans les hôpitaux et à domicile soit complétées.

3. Que l'expérience clinique soit donnée dans les salles de malades et à domicile.

4. Qu'il y ait un intervalle de temps suffisant entre chaque classe pour permettre à l'institutrice de continuer l'enseignement dans les salles de malades.

Strained orange juice has lost some of its vitamin C content which is normally contained in the pulp.

Interesting People

Alexandra MacKinnon Munn, who, since 1924, has directed the activities connected with the Nurse Registration Branch of the Department of Health for the Province of Ontario, has retired. Born in Coningsby, Ont., of Scottish and English parentage, Miss Munn graduated in 1913 from the Stratford (Ont.) General Hospital, winning the medal given for general proficiency. After a brief period of post-graduate study and experience in the United States, she returned to her alma mater as assistant superintendent of nurses, assuming the superintendency in 1918.

Through these intervening years, Miss Munn has exerted a powerful influence on nursing and nursing education. The provisions of the Ontario Registration of Nurses' Act were carried out under her jurisdiction. These included the regular inspection of all schools of nursing in the province as well as the responsibility of examining, regulating, and registering the members of the nursing profession. There has always been the closest co-operation between the provincial nurses' association and Miss Munn's department.

Imbued with high ideals for public service, and a staunch supporter of the nursing profession's best tradition, Miss Munn was ever willing to give of her wise counsel and rich experience. Kindly, cheerful, possessed of an unusual degree of charm and an all-saving sense of humor, hers is indeed a generous and mellow personality. Those coming in contact with her have benefitted from her great capability, her strength of character, her broad and deep understanding. Now, in her retirement, Miss Munn will have the time and opportunity to enjoy her much loved books, music and pictures, and, especially, to care for her garden.

Anne Wright was honored by the Board of Governors and staff of the St. Catharines General Hospital, Ont., on the occasion of the twentieth anniversary of her appointment as superintendent. Among other gifts made to her at this time was a silver tray and tea service.

Born in Galt, Ont., Miss Wright secured her teacher's certificate in 1909. After a few years in the teaching profession, she entered the Toronto General Hospital School for Nurses and graduated in 1919. She joined the T.G.H. staff as operating-room supervisor, advancing to second assistant superintendent of nurses in 1921. In 1925, she became assistant superintendent of nurses at the Victoria Hospital, London, Ont. From there she went to St. Catharines in 1927. Miss Wright served as chairman of District 4, R.N.A.O., for a two-year period.

A member of the St. Catharines Golf Club and the Business and Professional Women's Club, Miss Wright has always taken a helpful interest in community welfare activities. She served for seven years on the Y.W.C.A. Board in St. Catharines.

We join her associates in congratulating

Leatherdale, Toronto

ALEXANDRA MUNN

ANNE WRIGHT

Miss Wright and wishing her well in her work.

Priscilla Campbell recently celebrated her twenty-fifth anniversary as administrator of the Chatham Public General Hospital, Ont. In honor of the occasion, Miss Campbell was presented with a chest of silver at a testimonial dinner. Miss Campbell's election as president of the Ontario Hospital Association was noted on this page in the January, 1947, issue.

Vera E. Hayden was named assistant superintendent of the Kootenay Lake General Hospital in Nelson, B.C. In 1929, Miss Hayden graduated from the school of nursing of the K.L.G.H. She engaged in private and general duty for seven years before accepting a position as floor supervisor in her home school. Her varied experience there has given her an intimate knowledge of all aspects of the hospital's activities.

On April 6, 1947, **Agnes Douglas Carson,** the grand old lady of nursing in New Brunswick, retired from active duty after nursing for over half a century. Born in St. Andrews, N.B., on February 23, 1867, Miss Carson matriculated from the Charlotte County Grammar School in 1891. In November of 1892 she entered the Saint John General Hospital, then known as the General Public, as a probationer. At that time, the course of training was two years in length. Upon graduation, Miss Carson undertook district nursing in Saint John at the splendidly generous salary of $175 a year! In December, 1895, she went as a staff nurse to the New York Polyclinic Medical School and Hospital, becoming superintendent of nurses in 1896. She organized post-graduate courses for nurses there the following year.

In 1913, Miss Carson resigned from this position in order to go to Detroit to serve as organizer and superintendent of the Detroit Home Nursing Association. After nine years in that field of activity, Miss Carson returned to Canada, accepting the position of assistant

AGNES D. CARSON

superintendent of nurses at the Victoria General Hospital, Halifax. Three years later she resigned from that position to become superintendent of the Hospital for Sick Children in Halifax.

Home responsibilities called her to St. Andrews in 1929. Two years later she returned to active duty on the night nursing staff of the Saint John Tuberculosis Hospital where she has been employed continuously until her recent retirement.

Through the long years, Miss Carson has been closely identified with the professional organizations of nursing in every community in which she has worked. Apart from her professional activities, she has maintained a steady interest in other aspects of community endeavor. Her rich, full and useful life exemplifies the goal of service she set for herself so many years ago. Her guiding principle has been to live out the words: "Make no little plans. They have no magic to stir men's blood and of themselves will probably not be realized. Make big plans, aim high in hope and in work, and remember that a noble, logical aim, once recorded, will never die, but long after we are dust, will be a living thing, repeating itself with ever-increasing insistency."

Preview

What is being done in the rehabilitation of the paraplegic patients, especially the young veterans? **Dr. G. Gingras** has given us our first picture of the problem the paraplegic presents. **Dr. Paul Green** describes, in greater detail, some aspects of the rehabilitation program. Finally, **George Petrie,** himself a paraplegic, and editor of the magazine published by the Canadian Paraplegic Association, *The Caliper*, tells us some of the difficulties the paraplegic has to overcome in facing up to life situations.

In Memoriam

It is with sincere regret that we record the passing of **Mrs. Bedford Fenwick,** the gallant old lady of ninety, who maintained her lively interest in nursing through her post as editor of the *British Journal of Nursing* until her death on March 13, 1947. Mrs. Fenwick suffered a fractured femur last summer.

Over sixty years ago, as Ethel Gordon Manson, Mrs. Fenwick was matron of St. Bartholomew's Hospital in London, England. Her qualities of leadership were evidenced early when, in 1894, she founded the Matrons' Council of Great Britain and Ireland. Under her presidency, this body grew and after many successful Congresses in Britain, other countries were encouraged to form similar bodies. Mrs. Bedford Fenwick had the vision of an International Council of Nurses and, as its founder and first president, initiated this body in 1900, the first international organization of professional workers in the world.

"Just and due honor cannot be paid to so great a national nursing figure within the small confines of an editorial; the thrilling adventures of such a full and useful life can only be found in the absorbing pages of a biography." Her name will be remembered by nurses in every country.

Dorothy M. Barton, who graduated in 1920 from the Nova Scotia Hospital, Dartmouth, died recently. At the time of her death Miss Barton was assistant matron of the Prince Albert Sanatorium, where she had been on the staff for seventeen years.

Elsie Maude (Bickell) Brown, a graduate with the class of 1894, from the Montreal General Hospital, died in Montreal early in March.

Maud Carter, one of the first graduates of the Charlottetown Hospital, P.E.I., died recently in Worcester, Mass.

Marie Franey, who had served on the staff of the Nova Scotia Sanatorium for the past two years and previously had nursed in the United States, died recently in Kentville, N.S.

Lena Graham, who graduated from the Utica (N.Y.) General Hospital, died suddenly at her family home in Napanee, Ont.

Lily deVeer Hall, who graduated from the Toronto General Hospital in 1926, died at Wakefield, England.

Anne Charlotte Henderson, a native of Brantford, Ont., died recently in Toronto. Miss Henderson had engaged in private duty nursing for more than forty years, retiring in 1944.

Kathleen (Twiss) Howitt, who graduated in 1925 from the Toronto General Hospital, died at Preston, Ont.

Theresa Hushin, a graduate of St. Joseph's Hospital, Toronto, in 1925, died recently in Toronto. Miss Hushin organized the central service department of St. Joseph's Hospital and had been on the staff there for nineteen years.

Thyra B. Jordan, a member of the class of 1907 of the Toronto General Hospital, died in Toronto. Miss Jordan did private duty nursing for a few years and then entered into public health nursing with the Toronto Department of Public Health. She had retired three years ago.

Lucy (Dunlop) Kane, a graduate of the Ottawa General Hospital in 1940, died suddenly in Ottawa following an operation.

Kate (Johnson) Kerr, who graduated from the Toronto General Hospital in 1891, died in Toronto.

Etta Naomi Lane died in Saint John N.B. After completing her course in music at Mount Allison University, Sackville, N.B., Miss Lane taught music for some time before entering the school of nursing of the Bridgeport (Conn.) Hospital. After practising general nursing for a few years, Miss Lane became matron of the Fisher Memorial Hospital, Woodstock, N.B., and served there for thirteen years. In 1922, Miss Lane went to New York to work, retiring in 1927.

Idella Gertrude MacGregor, who had

been associated with the Victorian Order of Nurses in Ottawa for many years and who served as a nursing sister in World War I, died recently in Vancouver.

Lucy Marguerite Morin, of the class of 1918 of the Toronto General Hospital, passed away in Toronto.

Mary Margaret Shearman, a nursing sister in World War II, died suddenly at the Cornwallis (N.S.) Veterans Hospital.

Adelaide Sims, who graduated from the Royal Victoria Hospital, Montreal, in 1898 died in Ottawa in her eightieth year. After several years in nursing, Miss Sims returned to R.V.H. as night superintendent. She served in this capacity for many years then went to the United States where she held positions as superintendent in several hospitals. She retired five years ago.

Catherine Frances Spence, a native of Toronto who graduated from St. Luke's Hospital, Chicago, and served as a nursing sister with the American Army Nurse Corps during World War I, died recently in Toronto in her seventy-seventh year.

Kathleen Mary Stanton, a graduate in 1937 from the Royal Victoria Hospital, Montreal, died suddenly on March 20, 1947, at the age of thirty-two. Following graduation Miss Stanton joined the teaching staff at R.V.H. In 1943 she was appointed to the faculty of the McGill School for Graduate Nurses.

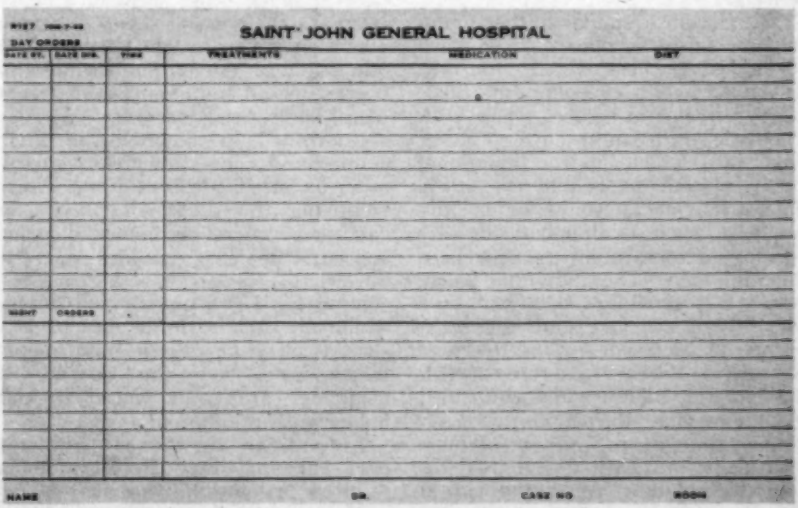
Cardex System for Nurses' Orders

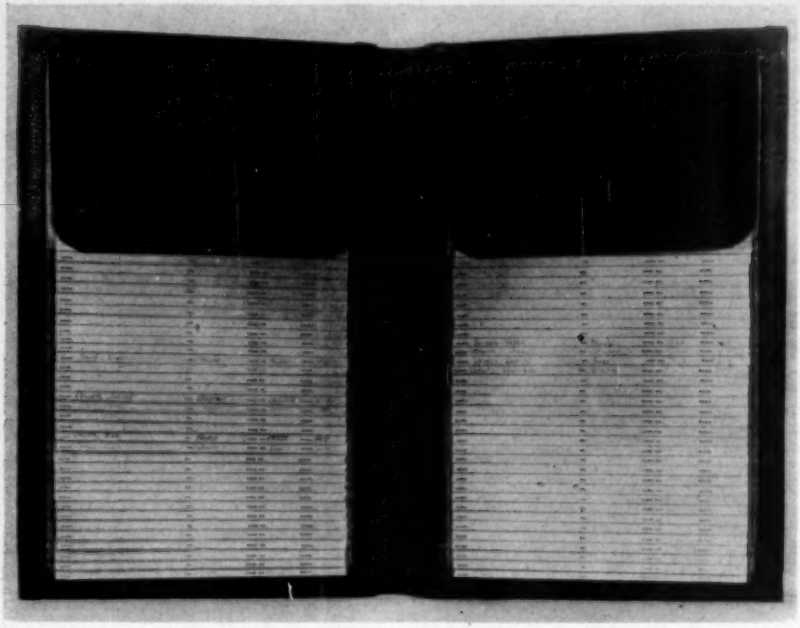
ISABEL RICHARDSON *and* CATHERINE MACLEOD

PATIENTS' records are constantly becoming a more time-consuming part of the ward program, due largely to the steady increase in the administration of drugs and other therapy, all the recording of which passes to the nurses.

The part of this responsibility which matters greatly is the method by which the records are clearly passed on to others in the changing nursing personnel of a mere twenty-four hours.

For accuracy and quick reference the following Cardex System is being





used at the Saint John General Hospital. After approximately eighteen months' trial it is felt that this system has considerably lessened the time spent on ward-bookkeeping, promoted the relaying of information from nurse to nurse, and has prevented unnecessary repetition and writing.

The Cardex is similar to that found in any business office. The card folder is leather-covered, fourteen by ten inches, keeping in place thirty-three card-holders, each with a plastic transparent covered lower edge into which fit the individual cards, placed one behind the other. The arrangement could be in any sequence, such as alphabetically, according to room numbers, diagnosis, doctors, etc. The individual card, which is reversible, has fifteen lines for day orders and nine for night orders on each side. Three vertical lines divide the card into three narrow and one wide column which are headed as follows: date started; date discontinued; time, for the narrow columns; treatment, medication, and diet, for the wide column. At the bottom of each card there is a line for the name of the patient and doctor, the case and room numbers, which are all visible through the transparent plastic. The Cardex is kept at the supervisor's or charting desk where it is accessible to all.

The difference between the Cardex cards and the order sheet of a chart is that the chart sheet contains all orders given by the doctor since admission of the patient, while the Cardex record contains present treatments only; the date an order is discontinued is recorded in that column and a line drawn through the order as an added precaution. When recopying the cards all previously cancelled orders are omitted, consequently one card provides room for all orders. To prevent the card becoming filled too quickly, all orders which are to last for a day or less such as blood chemistry, basal metabolism rate, etc., are written on medicine cards and placed in the holder with the patient's card.

In addition to the cards, a report called a Day Book is kept.

(*Please turn to page 386*)

Notes from National Office

International Visitors

The Canadian Nurses' Association extends a warm welcome to all international visitors who will be guests at the I.C.N. Congress in Atlantic City, N.J., May 11-16.

Student or Employee

The following commentary was published in the February 15, 1947, issue of *Nursing Times*. It provides much food for thought in our Canadian scene:

The *Lancet* suggested some time ago that all nurses should have a uniform two years' training—whether they were of the type suitable to train as assistant nurses only or able to qualify for State registration. Now it suggests that the plight of London County Council, and other municipal hospitals which are so short of nurses that wards must be closed, is the fault of the policy of the Rushcliffe Committee which has laid down uniform national salary scales for all student nurses. Previously, local authorities who had difficulty in obtaining candidates for training could attract girls, who had particular need for financial help, by offering more attractive salaries. Now all schools offer the same increased salaries.

What has been the result? The London County Council hospital service is reduced to less than half its pre-war complement of beds in spite of the fact that the number of nurses entering for the State examinations and qualifying has risen steadily; the majority of the large teaching hospitals have been able to increase their staffs to permit the reduction of hours (96-hour fortnight). Some are also trying to introduce the block system of training or the weekly study day which necessitates more candidates to maintain the ward staffs.

In the days before the Rushcliffe Scales were introduced the more popular training schools could offer modern buildings, first-class teaching and nursing equipment, had a reputation for making the student nurses happy, and often charged fees for the preliminary period, and paid comparatively low salary scales during training, yet these schools had long waiting lists because of their standing in the nursing and medical worlds. Other hospitals with less pleasant situations and less famous names could attract a moderate proportion of candidates by offering definitely higher salary scales. Now salaries are the same throughout.

The London County Council has met many of the points that are raised by the general public as main causes of the unpopularity of nursing, e.g., off duty restrictions, official hours of duty, etc. Whether nurse training schools, which have concentrated on improving the training and making it more sound educationally rather than doing everything possible to make life easier, have not chosen the wiser course is a question which these facts may partly answer.

The *Lancet* suggests that student nurses shall have a salary of £100 a year for each of their three years of training (£55 now being received).

The Student Nurses' Association has discussed the matter and many individual nurses have stated that they thought that better opportunities for learning and shorter hours on duty were much more urgent matters than increased salaries. They have appeared to realize that the more money they receive the more they become employees like the domestic and maintenance staff and the less they can expect in the way of educational facilities.

Those who think the paying of higher salaries the better way to attract suitable recruits imply that the student nurse says this because she knows it is expected of her and will please those in authority over her. The modern girl is not, in our opinion, so lacking in independent thought as her detractors would make her. She thinks for herself and says what she thinks. Good educational facilities make her work interesting and satisfying. The better her training the more she

understands and enjoys her work. If the ward sister is a sympathetic, keen teacher and senior colleague rather than her "boss," it makes all the difference to her enjoyment of her training. These things count with the average student nurse more than pounds, shillings and pence. The more her work and status approach to that of the physiotherapy student and medical student, the less will be the shortage of entrants into a profession which can be both intellectually and emotionally satisfying to a large number of young women with a considerable range of intellectual capacity.

On the other hand, it seems easier to give a little extra money to each nurse than to take time for the planning and the carrying out of the program necessary to obtain a good team of nurse, medical, and allied teachers, who will give the capable girl interested in nursing the professional training which will ensure intelligent nursing care for the sick who need it.

Questionnaire

In an endeavor to determine how it can be of further service to the nurses of Canada, the Canadian Nurses' Association is seeking information from individual nurses, through their local units of the provincial associations.

The Executive Committee of the Canadian Nurses' Association endorsed the request of the president, Miss Chittick, that a questionnaire soliciting opinions should be formulated for the guidance of nurses in submitting their suggestions. National Office staff has prepared this questionnaire which is designed to assist nurses in making suggestions as to their professional needs. When these questionnaires have been completed the information will be compiled and will serve as a guide in planning for travelling institutes or refresher courses, and also in planning the program for future conventions. Every effort will be made to meet the requests of the majority opinion of nurses.

It is hoped that every member of the C.N.A. will play her part in completing the questionnaire and returning it, as early as possible, to National Office.

CANADIAN NURSES' ASSOCIATION
Questionnaire

Province..... Date.....

District Chapter and/or Alumnae.....

1. Do you believe that a travelling institute or refresher course would be of value?.....
2. Would any of the following suggested topics be suitable or desirable? If so, please check:
   - (1) Public Relations: Methods and Functions of Public Relations Groups:
     - a. Personnel Policies and Practices.....
     - b. Personnel Management.....
   - (2) Selection of Personnel—Staff and Students.....
     Tests and Measurements.....
   - (3) Vocational and Guidance Programs.....
   - (4) Methods of Teaching:
     - a. Films and other visual aids.....
     - b. Group and individual techniques.....
     - c. Supervisory techniques.....
     - d. Staff conferences.....
       (Methods of conducting)
   - (5) Extra-Curricular Activities:
     - a. Hobbies—handicrafts.....
     - b. Creative writing.....

c. Music and drama.....
d. Public speaking.....
e. Organization of clubs.....
f. Current events.....
g. Personality development.....
h. Personal and social problems.....
i. Others.....

3. What topics would appeal most directly to the following? (List topics in order of preference.)

Institutional Nurses:

(a) Superintendent of Nurses.....
(b) Superintendent of Hospital.....
(c) Instructors in Schools of Nursing.....
(d) Supervisors in Schools of Nursing.....
(e) Supervisors (state special field).....
(f) Head Nurses.....
(g) Assistant Head Nurses.....
(h) Staff Nurses (general duty) (state special field).....
(i) Nurses in Special Hospitals, e.g., chronic, convalescent, aged.....

Public Health Nurses:

(a) Director of Nurses.....
(b) Supervisors.....
(c) Staff Nurses.....

Industrial Nurses: .....

Private Duty Nurses:.....

Other Groups:.....

4. What other topics or courses would you like to include?

General Topics:

.....
.....

Specific Topics:

.....
.....

5. What time would be most satisfactory for your community? Please check.

(a) All day.....
(b) Afternoons and evenings.....
(c) Evenings only.....

6. How large a group of nurses might be expected to enrol for such a course in your community?.....

7. Would a combination of local groups be possible or practicable in your area?.....

8. What accommodation is available for a series of lectures and/or demonstrations?.....
.....

9. What rental, if any, would be required for such accommodation?.....

10. Should a registration fee be charged to help defray expenses?.....

11. Other suggestions or comments from your group:.....

DATA ON STUDENT NURSE ENROLMENT IN SCHOOLS OF NURSING IN CANADA
for the year ending December 31, 1946—with comparative totals only for 1945.

Province	*First Year*		*Second Year*	*Third Year*	Total	Number to Graduate in 1947
	Probationers	Juniors				
Alberta	299	163	313	303	1,078	297
British Columbia	141	234	300	351	1,026	309
Manitoba	198	220	298	226	942	213
New Brunswick	207	101	190	194	692	193
Nova Scotia	186	157	255	217	815	220
Ontario	1,044	613	1,253	1,413	4,323	1,378
Prince Edward Island	40	27	32	39	138	39
Quebec: English	184	103	267	239	793	239
French	442	380	578	589	1,979	587
Saskatchewan	161	260	349	302	1,072	298
1946 Totals	2,902	2,258	3,835	3,873	12,858	3,773
1945 Totals	2,083	2,453	3,871	3,744	12,151	*in 1946* 3,598

Notes du Secrétariat de l'A.I.C.

AUX VISITEUSES INTERNATIONALES

L'Association des Infirmières du Canada souhaite la plus cordiale bienvenue aux visiteuses internationales qui seront les invitées du Conseil International des Infirmières lors du congrès qui aura lieu à Atlantic City, du 11 au 16 mai.

DES ETUDIANTES OU DES EMPLOYEES?

Sous ce titre le *Nursing Times*, journal officiel du Collège Royal des Infirmières de Grande-Bretagne, fait des commentaires susceptibles d'intéresser vivement les infirmières canadiennes. Le Collège Royal des Infirmières correspond à notre association nationale; il n'y a pas d'associations provinciales. L'Association des Etudiantes dont il est question est une association cadette du Collège Royal des Infirmières.

The Lancet est une des plus anciennes revues médicales d'Angleterre. "The Rushcliffe Committee" est un comité chargé un peu avant la guerre de faire une étude approfondie des conditions de travail des infirmières, etc. Ce comité a fait des recommandations qui ont été imposées à tous les hôpitaux. "The London County Council" est un corps

administratif. Des sommes considérables provenant des taxes sont employées à ériger, à maintenir des hôpitaux généraux et spéciaux, sanatoria, autres institutions, etc. "The London County Council" administre cet argent et ces institutions.

The Lancet suggérait, il y a quelque temps, que toutes les élèves infirmières, qu'elles aient les qualifications pour être admises aux examens d'enregistrement ou qu'elles n'aient que les qualifications pour devenir aides, suivent le même cours pendant deux ans. Maintenant le même journal dit que c'est la faute du "Rushcliffe Committee" si "The London County Council" et d'autres hôpitaux municipaux se trouvent en si mauvaise posture. Ces hôpitaux ont dû fermer des salles faute d'infirmières. La politique du comité Rushcliffe a été de recommander une rémunération uniforme pour toutes les étudiantes infirmières du pays.

Avant que cette échelle de salaires uniformes soit adoptée, dans certains hôpitaux où le recrutement était difficile, l'administration locale réussissait à attirer des candidates peu fortunées, en leur offrant une rémunération plus élevée que celle donnée dans d'autres écoles. Maintenant toutes les écoles doivent offrir la même rémunération.

Quel a été le résultat de cet uniformité? "The London County Council" ne peut offrir aux malades que la moitié des lits dont il dispose, faute d'infirmières, bien que le nombre d'infirmières diplômées se présentant aux examens de l'Etat (équivalente de la licence dans P.Q.) ait augmenté constamment. La majorité des hôpitaux ayant de grandes écoles d'infirmières ont été capable d'augmenter suffisamment leur personnel pour permettre de diminuer les heures de travail (96 heures par quinzaine).

Dans quelques écoles l'on essaie d'introduire l'enseignement périodique (bloc-système) ou la journée d'étude hebdomadaire (voir *Canadian Nurse*, fév. 1947, p. 141). Tout celà veut dire plus de personnel à l'hôpital.

Même avant que l'échelle de salaires Rushcliffe fut adoptée, les écoles d'infirmières les plus populaires étaient celles qui pouvaient offrir un logement moderne, un enseignement supérieur, et des facilités de travail. Ces écoles avaient la réputation de rendre les élèves heureuses. Souvent ces écoles demandaient à leurs élèves une contribution pour les premiers mois du cours et donnaient une très légère rémunération durant les trois années de formation; tout de même ces écoles avaient de longues listes de candidates, la réputation de ces écoles étaient connue aussi bien par les infirmières que par les médecins.

Comme nous l'avons déjà dit d'autres hôpitaux qui étaient dans une situation moins enviable pouvaient attirer une certaine proportion des candidates à l'étude de la profession en leur offrant définitivement un salaire plus élevé. Maintenant les rémunérations sont les mêmes partout.

"The London County Council" a fait des concessions sur des points, qui au dire du public sont les causes de l'impopularité de la profession—par exemple, on a enlevé certaines restrictions lorsque l'élève n'est par en service, des heures de travail déterminées, etc.

Il reste à savoir quelles sont les écoles qui ont adopté la ligne de conduite la plus sage: celles qui ont mis tous leurs efforts pour améliorer le cours d'infirmières en considérant d'abord le côté éducation ou celles qui ont fait en leur pourvoir pour rendre la vie plus facile.

Les faits suivants semblent vouloir répondre à cette question. *The Lancet* suggère que chaque élève infirmière reçoive un salaire de £100 ($420) par année durant les trois années du cours (elles reçoivent actuellement £55).

L'Association des Elèves Infirmières ont discuté cette question et un grand nombre d'infirmières ont tenu à donner leur opinion personnelle. Elles considèrent que: assurer des facilités d'éducation et des heures moins longues de travail sont des choses beaucoup plus urgentes que d'augmenter les rémunérations aux étudiantes. Ces élèves semblent réaliser que lorsqu'elles reçoivent plus d'argent, elles sont considérées comme des employées au même titre que le personnel chargé de la surveillance ou du personnel domestique et elles peuvent s'attendre à moins au point de vue enseignement.

Ceux qui croient qu'un salaire plus élevé pour les écoles d'infirmières serait un moyen d'attirer plus d'élèves, supposent que les élèves qui se sont prononcées contre ce projet l'ont fait pour plaire aux autorités dont elles dépendent et que cette réponse était attendue. La jeune fille moderne, selon notre opinion, a plus d'indépendance de jugement que ces gens veulent bien lui en attribuer. Elle pense par elle-même et dit ce qu'elle pense. Un bon enseignement lui crée de l'intérêt dans son travail et lui donne de la satisfaction.

Plus le cours est bon plus elle comprend et

aime son travail. Si l'hospitalière est une institutrice sympathique, enthousiasmée et une compagne aînée plutôt que l'autorité qui commande, celà fait toute la différence du monde pour le bonheur de l'élève durant son cours. Celà compte plus pour la moyenne des élèves que l'argent. Plus le cours de l'étudiante infirmière se rapprochera du cours de la physiothérapiste ou de l'étudiant en médecine, moins il manquera de candidates à une profession qui peut donner à un grand nombre de jeunes filles satisfaction au point de vue intelligence et émotion.

Par contre, il semble facile de donner un peu plus d'argent à chaque infirmière que de prendre le temps de préparer un programme, de le mettre à exécution afin d'avoir un bon personnel enseignant, infirmières, médecins, et autres professeurs capables de donner à une jeune fille intelligente une formation professionnelle et aussi assurer au malade les soins intelligents.

L'Association des Infirmières fait une tentative pour déterminer comment elle peut mieux rendre service aux infirmières. Elle demande des renseignements à ses membres par l'intermédiaire de groupements moins considérables que le sien.

Le Comité de Régie de l'A.I.C. appuie la demande de notre présidente, Mlle Chittick, à savoir, qu'un questionnaire soit envoyé afin de servir de guide dans les suggestions que vous soumettrez.

Lorsque ces questionnaires seront complétés, nous empilerons les informations reçues, elles nous serviront de guide pour les cours ambulants et post-scolaires et aussi pour préparer les programmes des congrès futurs.

Nous ferons toute notre possible pour répondre aux demandes générales des infirmières.

Nous espérons que chaque membre de l'A.I.C. dira son mot lorsque l'on répondra à ce questionnaire.

Cardex System for Nurses' Orders

(*Continued from page 380*)

In this, such information as result of treatments, temperature, pulse, respiration, general conditions of patients, admissions, etc., are briefly recorded; this is used together with the cards in giving the evening report. The night nurses in turn make a similar short summary of all clinical data of patients in a Night Book which is given by the senior night nurse to the day staff. By using the cards with these reports much repetition of writing is avoided.

When a new patient is admitted a card is made out and placed in the folder. As soon as the doctor's orders are written they are transferred to the card and chart. On discharge of the patient, the card is discarded and the space left empty.

In addition to the record of orders the Cardex System has other time-saving values.

To the student or general duty nurse: It enables her to easily check and become familiar with the diets, treatments, and medications. By closely observing the doctors' order book all new orders are made known to her through the day; new orders are copied on the cards as soon as possible after they have been given. When charting she has the opportunity of comparing the day or night book with the cards, thus knowing whether she has all information required before proceeding with her charting.

To the new or private duty nurse: She may easily locate patients for telephone messages, visitors, etc., through referring to the Cardex.

To the supervisor or head nurse: It provides a good reference file when making out discharge slips, transfer slips, diet sheets, etc., thus saving the time and energy of going from chart to chart getting correct data, such as case number, doctor's name, etc. The blank spaces provide an easy means of checking the position of empty beds.

From the above information it seems the system has a time-saving value in more than one situation. It has a certain amount of flexibility useful in different services where the method of ward-bookkeeping varies. Finally, it seems to fit into the present day program of any busy ward service.

STUDENT NURSES PAGE

Toward a Better Understanding

MARGARET MCCULLOUGH

Student Nurse

Toronto General Hospital School for Nurses.

IN OUR SCHOOL for Nurses, two weeks are set aside for a "Public Health" term. Each student is assigned to a definite ward where she is given the care of three patients. She makes a thorough study of each patient's history, his home life, and all factors affecting his recovery. During this term the student is especially alert to the health teaching which is essentially a part of all good nursing care. This teaching is emphasized in informal conferences with our health education instructress. Various patients are discussed, their habits, and what can be done to help them most.

In conjunction with the ward term, it is arranged for the student to "go out" with a nurse in the Public Health Department. The nurse has her work so arranged that the student spends two mornings at the school clinic, one afternoon at a Child Health Centre, and the remaining three afternoons on public health visits.

The visit which was outstanding in my experience was one to trace tuberculosis contacts. Miss R received a report that "Mrs. S was a patient on a medical ward in a general hospital, with a diagnosis of pleurisy with effusion, presumptively tuberculosis. Her mother's home must be visited to list contacts."

The home was one familiar to Miss R through school visits. She made the visit with several things in mind:

1. To list contacts and make appointments at the Gage Institute* for free chest x-rays.
2. To see if the family needs assistance in the event of the patient's return.
3. To review the conditions of the home and the ability of Mrs. M to care for her daughter.

The house as we approached it looked fairly well kept, but the interior was crowded and poorly lighted. Mrs. M greeted us with "Well, I guess you've come to see the patient; she arrived today." We followed her up a long flight of stairs to the bedroom. Mrs. S was lying chatting with a young man who was sprawled across her bed. He was later introduced as "the star boarder." We first entered into a discussion about blankets. Mrs. M wanted to pile blankets on the patient and open the window which put a direct draft on the bed. The room was filled with the stifling odor of coal-gas and the air was blue with cigarette smoke. Miss R suggested putting a board across the window as a draft deflector. The discussion turned to Mrs. S's stay in hospital and her version of hospital situations common to us was very amusing.

*Operated by the National Sanitarium Association and the Toronto Hospital for Tuberculosis, Weston, Ont.

Very gradually Miss R arrived at the problem of contacts. Mrs. M was quite responsive, gave her the probable contacts, and assured us that the appointments would be kept faithfully.

When approached on the problem of caring for her daughter, Mrs. M was a bit doubtful about trips upstairs, bed-baths, etc. Miss R suggested the possibility of having a Victorian Order nurse or similar agency come in to help. Mrs. S had been well-informed in hospital as to her conduct at home — complete rest for two months; but to us it seemed doubtful if she would or could carry this out. To complicate matters she had a very active two-year-old son. Miss R enlisted the aid of the mother and re-emphasized the importance of complete rest and proper diet.

When Miss R asked about financial assistance, there was a difference of opinion between mother and daughter. Then Mrs. M explained the situation. Mrs. S and her husband had been separated for over a year with considerable hard feelings between them. If she asked assistance she was afraid that in subsequent investigation her husband would be contacted, and if he could prove her unable to support her son, the husband would claim custody. Miss R promised to find out about it and, if possible, arrange care through a fund available to those recovering from tuberculosis.

The visit was instructive in many ways. I found it interesting to note how many problems arose in one case, how each was tackled separately and a tentative solution found. We left the home feeling that we had accomplished much in a short visit.

Another of the interesting patients was Mr. T, a middle-aged bachelor, who was convalescing from a coronary thrombosis. Most of his health problem lay in his mental attitude. He found it very difficult to "stick" to the coronary routine. He worried about his hospital bill. He imagined himself acquiring the symptoms of other cardiac patients, such as, shortness of breath, cyanosis, edema, etc. His eating habits were also a problem in that he disliked institutional cooking and did not like being fed.

In casual conversation I found that he had a family history of cardiac complaints. This made an ideal opening for health teaching about cardiac disease. I was able to explain why he was on coronary routine, why it was so important that he be fed, bathed, and moved. He was very interested in the different heart diseases, the symptoms, the treatments, and the necessity of avoiding strain, overwork and excess in everything.

The atmosphere in the ward was very congenial and I encouraged his joining in with the other patients. With a little extra time we were able to convert the dreaded mealtime into a more enjoyable period.

When Mr. T talked to the other patients on the ward, he began to see that his troubles were comparatively few. After all, he had a secure job in a prominent shoe store and lived in a pleasant rooming-house. Although he had no hospitalization insurance he had some money saved and had no family to support.

He seemed to be getting along very well and I felt that I had had some part in helping his convalescence.

The experience of my two weeks was very interesting as well as educational. The home visits gave me insight into the home ties of the average ward patient. The careful personal study of the patient made me realize that patients have multiple problems. Having seen and heard of some of the home backgrounds we cannot help but realize how much we can teach our patients if we take the time and show the interest.

A group of nuns recently attracted much attention at a western Canada railway station because of the beautiful nylon veils they were wearing. In response to enquiries, one of them explained that they were going to work in southern China and were wearing nylon because of its suitability to the climate of that country.

Hernia in Infants

HERNIA is the protusion of a portion of the contents of a cavity through an abnormal opening in the wall which normally confines it. Originally it was believed that a portion of the peritoneum was ruptured in a hernia; the condition is still termed as "rupture" by many.

Hernia may occur at many points in the abdominal wall. The most common sites of hernia in infants are at the umbilicus and through the inguinal canals and they are identified by these descriptive terms. Hernia may be either congenital or acquired. Cases of the latter occurring in infants, however, are usually dependent upon conditions which are congenital.

Umbilical hernia occurs very commonly in infants, especially those who are markedly undernourished. It is found more often in female than in male infants. The congenital form, exomphalos, may be observed as soon as the infant is born. It may be very small in diameter. It may be apparent only when the infant cries or strains. It rarely strangulates. As a rule these small hernias do not require any active treatment since they disappear spontaneously as the nutritional state improves or as the infant grows older. Placing a strip of adhesive across the umbilicus in such a way as to prevent the hernia from protruding is the simplest and most effective method of treatment. The doctor will direct the nurse to fold the skin over the umbilicus and strap it in place. Sometimes a large button or coin, wrapped in gauze, is applied directly over the hernia before the adhesive is put on. The adhesive may be a single strip, two inches wide, stretching from hip to hip. Another method is to leave a square over the umbilicus and cut each end in inch-wide tails. Crossing these strips in applying them provides a stronger support. Since the adhesive must remain over the abdomen for several months at least, there may be some irritation of the skin. Should this develop, it is wisest to permit an interval without the retaining straps, reapplying them when the skin is well. An umbilical hernia that has had no treatment until the infant is ten or twelve months old does not respond to this simple form of treatment. The older the child the more likely he will require surgical treatment.

Inguinal hernias occur in the inguinal canal, the space in the groin through which, in the male infant, the testes descend from the abdominal cavity to the scrotum and the spermatic cord enters the abdomen. In the female infant, the round ligament of the uterus passes through this opening. Normally this space closes completely. When it is only partially closed, a protusion of the peritoneum occurs forming a small sac. Weakness of the tissues may permit this form of hernia in female infants though three-quarters or more of the inguinal hernias occur in males. Acquired inguinal hernia may follow trauma or strain of any type such as a severe bout of whooping cough. An inguinal hernia rarely causes the infant any discomfort unless it becomes strangulated when the symptoms of intestinal obstruction will arise. Though the latter seldom occurs, immediate surgical intervention is necessary when it does. Even very young infants tolerate a hernia operation well if they are vigorous. Usually, keeping the hernia reduced by the constant application of a suitable truss will be sufficient to control it. A satisfactory truss for a young infant can be made from white wool. A band encircles the abdomen with supporting strands around the buttock, the knot being applied over the hernia. Since the truss will have to be changed frequently, when wet or soiled, the wool can be washed regularly, using warm water, a non-irritating soap, and thorough rinsing.

Book Reviews

Nursing Care in Chronic Diseases, by Edith L. Marsh, R.N., S.C.M. 237 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1946. Illustrated. Price $3.25.

Reviewed by Pearl L. Morrison, Superintendent, Queen Elizabeth Hospital, Toronto.

A nursing textbook dealing with the care of the chronically ill has long been a definite if not recognized need. The chronically ill are now, by their rapidly increasing numbers, demanding more public attention, and the problem can no longer be pushed into a corner and forgotten.

Miss Marsh in her first chapter on "Definitions" will bring some surprises, and it is hoped increased interest. As she goes on to discuss "long-term" illnesses in need of long-term ability from a nurse, she definitely shows that more than practical skill is needed to care for a mind *and* a body. The nurse must *have* something definite of herself to give.

Miss Marsh clearly presents for study, not only chronic diseases, but the persons suffering from them, as sick people in need of more and better nursing care. She feels more suitable preparation must be given in the schools of nursing if graduate nurses are to be able to meet this ever-increasing need of the sick and the community.

Certainly every nurse everywhere needs Miss Marsh's book, and I feel sure will find it a most interesting study.

Anatomical Charts for the Training of Nurses. Edited in collaboration with prominent medical authorities, and accompanied by a booklet on the system portrayed by the chart. Published by Rudolph Schick Publishing Co., 700 Riverside Drive, New York City 31.

Reviewed by Muriel Archibald, Science Instructor, Homoeopathic Hospital, Montreal.

Among other charts portraying certain systems, there is one illustrating the respiratory system, a life-size colored chart, showing in excellent detail organs and accessory organs of this system and their location in the body. The booklet accompanying this gives a simple and uncomplicated description of the respiratory system and would be good material for high school students.

Five charts are used to show the various organs of the endocrine system. One is a colored, life-size chart showing glands as they are placed in the human body. The other four are in black and white and give examples of the result of hypo- and hyper-function of certain endocrine glands. The examples shown of male and female glandular dysfunction are likely to impress themselves on the student's memory, thereby helping them better to understand and remember those organs associated with the examples. The interdependence of these glands one to another, and especially to the pituitary gland, is well illustrated.

The charts should prove very useful teaching material but, unfortunately, the paper on which they are printed is too thin and too easily torn to have a very long life.

Sir Frederick Banting, by Lloyd Stevenson, M.D. 446 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1946. Illustrated. Price $6.00.

Reviewed by Katherine MacLaggan, Public Health Nurse, Westmorland County, N.B.

Dr. Stevenson states that Sir Frederick Banting resisted all efforts towards a formula, and in this biography he has succeeded in portraying no standardized character. Those who read this book will have a better understanding of this great Canadian. It is written in a style one feels would have been acceptable to Banting himself. Factual and technical knowledge are presented in an interesting and reasonable manner. The doctor, scientist, artist, teacher and patriot are readily understood through the pen of the writer. It is necessary to read between the lines for insight into the complications of his private life, which is as it should be.

The chapters "The Magic Islands" and "The Prophet in the Valley of Bones" should be presented to every student nurse early in her training so that she may appreciate the value of medical science to humanity. Banting's contributions were many, but in the minds of the majority his gift of insulin to the world was his chief contribution. His "biggest experiment," however, was in terms of guidance to those who worked with him in medical research.

Dr. Stevenson's biography of Sir Frederick

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Banting will have a wide reading public, but nurses will readily appreciate its value to them, and count this book as a necessary part of their hospital and personal libraries.

Toward Mental Health, by George Thorman. 32 pages. Published by Public Affairs Committee, Inc., 22 East 38th St., New York City 16. Distributed in Canada by The Canadian Forum Book Service, 16 Huntley St., Toronto 5. Public Affairs Pamphlet No. 120. Illustrated. Price in U.S.A., 10 cents; in Canada, 15 cents.

Written in simple direct language, to be readily understood by men and women without a medical or nursing background, this little pamphlet would be useful as teaching material for every public health nurse. Everything that she can do to help cut the toll which mental illness takes will pay dividends. While this pamphlet was written to apply in the United States, most of the items in the suggested program are equally applicable in Canada. The material may be read with profit by every nurse — we, too, are subject to feelings of hostility, of guilt, fear of failure, insecurity. There are the things out of which neuroses are made.

A Review of Nursing, by Helen F. Hansen, R.N., M.A. 854 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 5th Ed. 1946. Price $3.50.

Reviewed by Mrs. Lois MacDonald, Instructress of Nurses, P.E.I. Hospital, Charlottetown.

All who possess this excellent "Review of Nursing" will find it most helpful in reviews of the many nursing subjects. It will be especially useful to the instructors as it is time-saving since the reviews are systematically arranged. Often we are prone to ask questions in one set way; by using these reviews the student may view the subject from different angles and gain a broader knowledge.

The correlation of chemistry with nursing is especially good as too often students and teachers think of this as a separate study rather than connecting it with the various nursing procedures.

The students will find this book very valuable as they may test themselves in the different subjects. If they are unable to answer many questions without referring to answers, it will prove to them that much more study and learning is required in that subject.

The busy head nurses and supervisors will find this book a very quick and effective means of review.

Orthopedic Nursing, by Robert V. Funsten, M.D. and Carmelita Calderwood, R.N. 602 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co., Ltd., 388 Yonge St. Toronto 1. 1943, reprinted 1946. Illustrated. Price $4.25.

Reviewed by Margaret Orr, Superintendent, Shriners' Hospital for Crippled Children, Montreal.

This is a book written jointly by an orthopedic surgeon and a nurse consultant in orthopedic nursing, dealing mainly with the underlying principles of the fundamental surgical and nursing techniques in the care of orthopedic patients.

At the outset the authors state that it is not intended to be encyclopedic, therefore, it is not designed to "take the place of a comprehensive reference text on the subject of orthopedic surgery."

The book is divided into twelve sections with each section followed by a list of references and, with the exception of the first section, a group of questions for study.

The first section takes the form of an introduction for the teacher and the student, and is entitled "Toward a Complete Understanding." This is a valuable chapter to the student nurse as it not only emphasizes the place of the nurse in the scope of nursing care for the orthopedic patient, but also the place of orthopedic nursing skills in the general nursing course, and how closely they may be related to all branches of nursing in order that the patient may be treated as a whole rather than in a series of disconnected procedures.

Sir Robert Jones is quoted as having said, "It can never be realized too widely that deformity is an unnatural and preventable affliction, which treatment may alleviate or cure, but which a more complete understanding could abolish."

The remainder of the twelve sections cover all aspects of orthopedic nursing care, in relation to both children and adults. The book is printed in clear type, copiously illustrated, and should prove a ready source of information for all nurses.

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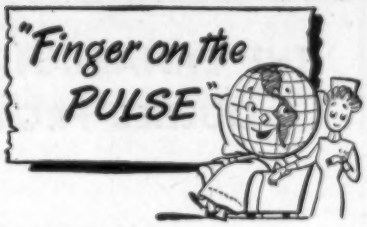


Pushover: A party of hunters in Alberta pumped six bullets into a moose, but the dead animal wouldn't lie down. The hunters got around that by simply pushing the moose over with their hands.

Exceptional student: There are drawbacks to educating inmates, the superintendent of Washington's State reformatory discovered. One inmate learned to read and write during a six-month stretch and is now back on a forgery charge.

I oh oh! A short-of-cash housewife in Mobile, Alabama, opened her baby's piggy bank and found only a slip of paper. On it was written: "I. O. U. $5 (Signed) Daddy."

Yum, Yum: A customer in a Uniontown, Pa. restaurant eyed a waitress up and down and said, "You're good — good enough to eat", and promptly bit her hand.

"I saw through that chap long ago!"

Improved Artificial Hand

A new artificial hand which represents a major advance in the manufacture of prostheses for amputees has been announced by the United States Army. Both cosmetically and mechanically this hand is far superior to anything that has been perfected to date. The "hook" hand at present is the best that can be provided from a utility standpoint. In this new advance, the hand operates more effectively for the amputee and, in addition, it has the appearance of a natural hand. These devices are not on the market now and will not be until civilian industry gets them into production.

The life-like appearance of the glove, which is part of this new hand, is of tremendous value to the morale and psychological well-being of an arm amputee. The army laboratory has produced a glove of plastic material, simulating a natural hand, even to the fingerprints, skin structure and hair. It is seamless, flexible, and of light weight, is less inflammable than clothing, and waterproof. The careful compounding of the materials used has resulted in a glove of greater resistance to the deteriorating effects of the atmosphere and chemical re-agents encountered by a hand in normal use.

The development of the hand through its progressive stages has resulted in a series of new components, each adaptable to a different combination to provide a number of finger and hand movements covering a wide range of utility in a completed hand. This hand is designed to impart all of the force from the controlling means into the first and second fingers, which meet conjointly with the thumb. A force amplifier is built into the hand, which transmutes the initial impulse and compensates for mechanical losses, thus giving the amputee a greater grip at the fingertips for each one-pound of force exerted on the control cable than he has ever been able to with any other artificial hand—a tremendous advantage over any existing prosthesis. Hands now in use produce only about 4 pounds of grip for 15 pounds of pressure. This new hand gives about one pound of grip for one pound of pressure.

Pressure at the fingertip has been one of the outstanding problems in prosthetic manufacture since the inception of artificial hands, and through the development of this efficient, simple force amplifier, the problem now becomes one of limiting the amount of fingertip pressure within controllable bounds. Sensitivity as to the strength of the hand is achieved far more efficiently and positively than in any of the hands produced in the past; it is of great benefit to be able to gauge the potentiality of the applied force. The first and second fingers are equalized to assure a strong grip on objects grasped between the thumb and the fingers, providing in normal use and over normal contours the exertion of pressure from three points—this three-point contact prevents twisting or slipping of an object grasped.

The third and fourth fingers of the hand would ordinarily add little to the value of a mechanical grasp, and are, therefore, designed only for prolonged strain in carrying a handled object, such as a suitcase. These fingers can also be used as a control lever for locking and unlocking the movable fingers.

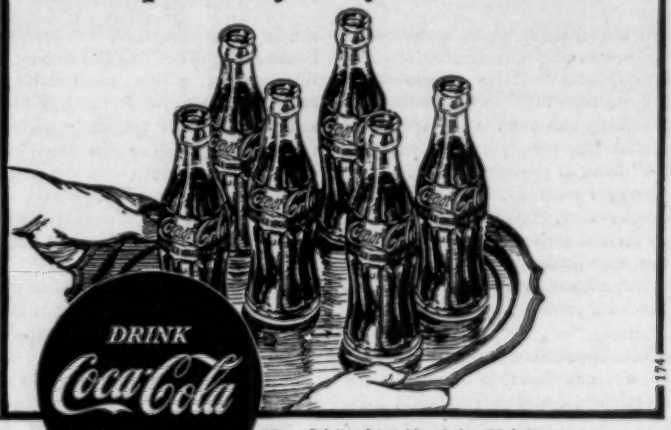
Two miniature clutches of great strength, capable of releasing easily under full pressure, are used in the hand. One is used to preposition the thumb, permitting a wide latitude in the size of the object grasped. This positioning can be made without awkward movements or strained unnatural contortions and can be released in the same manner by a simple rolling motion against one of the clutches. The other clutch is used when wanted to lock the fingers in a position or grip desired by the amputee to relieve strain on the controlling means.

The weight of the glove is between two and three ounces, and the proposed completed hand will weigh approximately twelve ounces. The objective to be attained was that the hand perform as many functions of normal living as possible, without involving a high degree of complexity, weight, or need for prolonged training in its use.

—News Notes No. 58

The diagnosis of pernicious anemia depends on the condition of the blood and the character of the stomach secretion. In all cases there is a lowering of the hydrochloric acid to a marked degree. Nervous symptoms and sore tongue aid in confirming the diagnosis, as do the evidences of changes in the spinal cord.

Hospitality in your hands



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Rutin

A new drug, rutin, derived from certain plants, has been described as a preventive of latent capillary hemorrhage. Not least is the apparent value of rutin in the preventive therapy of brain and eye hemorrhages which are seen so often in high blood pressure.

Rutin is widely distributed in nature, being found in buckwheat leaves and blossoms, tobacco leaf, rue herb, tomato stems, white hydrangea, yellow pansies, the leaves of the common elderberry, and in many other flowers and leaves.

Believing that abnormally weak capillaries might be a factor in the production of certain hemorrhages occurring in cases of hypertension, research scientists had to develop a standard of measurement of the ability of the capillaries to resist pressure. It was believed that if the capillary fragility could be strengthened there would be no more "blow-outs" of the all-important circulatory system and hemorrhages into the internal organs would be placed under control for the first time. Rutin appears to fill the role since it is known that it can strengthen the capillary walls.

—*Canadian Pharmaceutical Journal*

Medical Films

Medical teaching is making increasing use of films, but up to the present there has been no organized endeavor to fit film production to the medical curriculum in Canada. Although excellent films have been made here and abroad by commercial concerns with the close co-operation of the profession, most of the activity in this field has been carried on by private individuals and institutions.

The first attempt at co-ordination on a national basis is now being made by the recently formed Medical Committee of the Canadian Scientific Film Association. This body will have representation from the main medical organizations in the country, and will somewhat parallel the collaboration of the Royal Society of Medicine with the Scientific Film Association in the United Kingdom in surveying and co-ordinating medical film activities there.

One of the CSFA Medical Committee's first tasks will be a survey of existing medical motion pictures of Canadian production. This survey will meet a long-felt need and will also assist in the expansion of the medical film library brought together by the National Film Board. The committee recognizes that there are many films of teaching and historic interest whose use should be more widespread, and it solicits information on each and every medical film produced in Canada. It is hoped that much dormant film footage will be uncovered.

The cataloguing of all existing medical films is the indispensable first step towards bringing about an orderly development in this field, and those members of the profession who have made or possess medical motion pictures are forthwith urged to communicate with: The Medical Committee, Canadian Scientific Film Association, 172 Wellington Street, Ottawa, Ontario.

First Admissions

Of the 7,664 first admissions to mental hospitals in Canada during 1945, 83.0 per cent were in the psychoses group; 12.2 per cent were mental defectives; 1.8 per cent were epileptic; 1.0 per cent were alcoholics and drug addicts (without psychosis) while 1.9 per cent comprised all other types. The average age of all admissions was 42.1 years.

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Session 1947-48

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II. Courses for Graduate Nurses: (Entrance requirement: Junior Matriculation). These are one-year Certificate courses as follows:

Nursing Education: General (preparation for teaching).

Nursing Education and Administration: An advanced course.

Public Health Nursing: General.

Public Health Nursing: Advanced courses in Administration and Supervision, or other specialty.

Clinical Supervision in:
(a) Medicine
(b) Surgery
(c) Obstetrics
(d) Paediatrics
(e) Operating-room procedure
(f) Psychiatry or other specialty as selected.

Note: In Clinical Supervision the student chooses one of the above as her field of study for the entire year.

III. A Special Arrangement for Graduate Nurses: Whereas a candidate with senior matriculation standing may register in the Faculty of Arts of this University and complete the Pass course in Arts in 3 years, and, whereas some of the subjects of this Pass course in Arts are identical with certain subjects included in the above Certificate courses, it has been arranged that a graduate nurse who registers in this Pass course in the Arts Faculty may register at the same time in this School and, during the same 3 years, cover the requirements for the Certificate in one of the courses as described above, except that the courses in Clinical Supervision are not included in this arrangement.

For information and calendar apply to:

THE SECRETARY

Of total first admissions, 36.9 per cent were in dependent circumstances, 50.5 per cent were reported as marginal, while 8.8 per cent were in comfortable circumstances. As in previous years, the largest number of first admissions came from the three occupational groups of Personal Service, Laborer, and Agriculture.

A total of 6,551 patients were discharged from mental institutions in Canada during 1945. Of these, 30.2 per cent were discharged as having recovered, 53.1 per cent as improved, 14.7 per cent as unimproved, and 2.0 per cent as "without psychosis." The average length of stay of discharged males was 1.4 years and for females, 1.2 years.

— *Report of Mental Institutions, 1945.*

Salt, basis of Canada's alkali industry, came to light in vast quantities with the discovery of the great salt beds of Western Ontario during the drilling for oil which occurred in the 1860's. At Windsor, Ont., salt has been produced since 1890.

Nursing Sisters' Association

The nursing sisters of the *Saskatoon Unit*, who served in World War I, recently turned over their positions of office to those who served in World War II, with the following results: President, A. L. Scrimshaw; vice-presidents, G. Porter, A. Chudy; secretary-treasurer, V. Bergreen. The original association, although only composed of five members, was very active. The present membership numbers twenty-five, with meetings held on the third Wednesday of each month. The newly-organized unit so far has packed three parcels for British nurses.

Alberta

The following are recent changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Mrs. Jean Doolan* and *Mrs. Mary Taylor* to New Brigden and Worsley for half-time service; *Jeannette McInnis*, formerly of Rosebud health district, Didsbury, to Sunnynook.

Resignations: *E. Standing* from Plamondon, *M. G. White* from Craigmyle, and *A. Mitchell* from Dixonville, all to be married.

M. Maynes has been granted a year's leave of absence. She will be working at the Calgary Child Welfare Clinic.

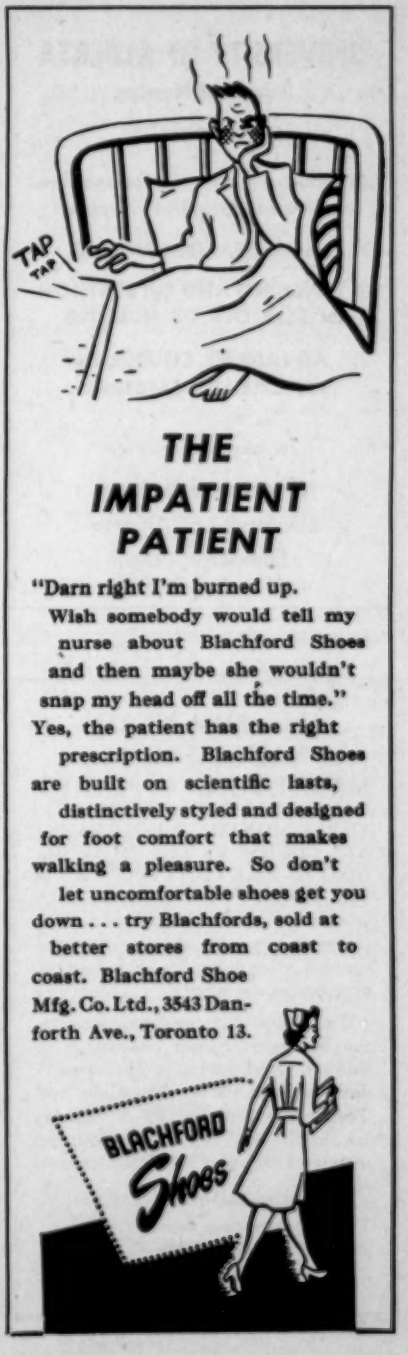
Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

New Brunswick: *Harriet Hughes* (Ottawa Civic Hospital), *Cecilia Markey* (St. Joseph's Hospital, Saint John), *Rita Cook*, and *Irene Loggie* (Hotel Dieu, Campbellton) appointed to newly-opened outpost hospital at Rexton. *Kathleen DeMarsh* (Saskatoon City Hospital) is at Miscou-Shippegan nursing station. *Elsie Hamlon* (Soldiers' Memorial Hospital) has opened the nursing station at Alma.

Nova Scotia: *Beth Nicholson* (Prince Edward Island Hospital) is conducting a community nursing service at Pleasant Bay, Red River, Cape Town.

Ontario: *F. I. McEwen* has retired as field superintendent of the Outpost Hospital Department and *I. Brand* is her successor. *Miss Franks*, of Beardmore, has been transferred to Emo and is replaced by *Mrs. Gwen Ridley*. *Betty McIntosh* has returned from leave of absence and is on duty at Lion's Head. *Hazel Schultz* returned to the staff and is in charge at Mindemoya. *Grace Johnson*, of Mindemoya, is on leave of absence and is replaced by *Mrs. Jean Kirkness Noble*. *B. Easton*, although retired, has been doing relief work between Hornepayne and Nakina. *Jean Marsh* has been transferred from Hawk Junction to Bracebridge, and *Hazel Ball* from Kirkland Lake to New Liskeard. Misses *Hilts* and *Cole*, of Dryden, and Miss *Walsh*, of Espanola, resigned to be married as did *Margaret (Plewman) Hill*. *Nora Leuty* (Woodstock General Hospital) has been appointed to Beardmore and *Catherine Real* (Wellesley Hospital) to Hawk Junction. *Ethel Cook* is doing relief work at Beardmore. *Helen Weston* (Belleville General Hospital) is on duty at Englehart. *Mrs. Florence Watson*, formerly of London, England, is now at Bracebridge, and *Margaret Richardson*, *Barbara Torrance*, and *Irma Westinberg* (Wellesley Hospital) are at Dryden. *Vivian Goodreau* (Chatham General Hospital) is stationed at Hornepayne and *Kathleen Bennett* and *Jessie Richardson*, who both gave V.A.D. service overseas during the war, are nurse assistants at New Liskeard and Englehart.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The course has been approved by the Registered Nurses Association of Ontario, the Director of the Department of Tuberculosis Prevention, and The Deputy Minister, D.V.A. **Salary:** 1st month—$80; 2nd month—$90; 3rd month—$100—plus full maintenance.

For further information apply to:

Miss Ellen Ewart,
Supt. of Nurses,
Mountain Sanatorium,
Hamilton, Ontario

M. E Bartlett has recently transferred from the Junior Red Cross to act as director, Volunteer Nursing Services, while *D. Crozier*, who was on the Junior Red Cross field staff, is now acting director, Junior Red Cross.

Prince Edward Island: *V. Darrow* has returned from the R.C.A.M.C. to direct the crippled children's program of the Junior Red Cross.

Saskatchewan: *Alice Tell*, of Endeavor outpost hospital, and *C. Fink*, nurse in charge at Loon Lake outpost hospital, have resigned to be married. *Dorothy Tansley* is now at Loon Lake and *Mrs. H. A. Robson* is nurse in charge at Pierceland outpost hospital.

M.L.I.C. Nursing Service

Germaine Dupuis (Hotel Dieu de St. Joseph, Montreal, and University of Montreal public health nursing course) has been transferred from Jonquière, P.Q., to the Montreal staff of the Metropolitan Life Insurance Company nursing service.

News Notes

ALBERTA

EDMONTON:

Madeline McCulla, the president, was in the chair at a recent meeting of Edmonton District, No. 7, A.A.R.N., when Dr. Kenneth Hamilton was the guest speaker. His address on "Psychiatry" provided the members with a new approach to cause and prevention in psychosomatic medicine. A donation of one hundred dollars was made by the members for the Rest-Break Homes operating in England for civilian nurses.

Royal Alexandra Hospital:

Suggestions that nursing schools be state-supported, organized as independent units of the hospitals, and that nurses be treated as students for a training period of two years, were made by Rae Chittick, president of the C.N.A., at the twenty-first annual banquet of the Royal Alexandra Hospital Alumnae Association. Miss Chittick was addressing the fifty-eight members of the R.A.H. graduating class, who were honor guests at the dinner. Her subject was "I Have a Life to Give."

More than two hundred and fifty guests attended. Seated at the head table were: Miss Chittick; Mrs. N. Richardson, alumnae

president; V. Chapman, past president; Margaret Fraser, superintendent of nurses; Misses A. Lysne, I. Johnson, C. Zender, D. Anderson, and Mmes T. R. Clarke, A. McDonald.

The toast to the King was proposed by Mrs. Clarke, to the Alma Mater by Miss Chapman, to the graduating class by Miss Lysne. N. Bentley replied on behalf of the graduates. The president read a telegram of greetings from the Vancouver alumnae members who were also holding a banquet. Miss Zender, the soloist, was accompanied by Miss Anderson.

MEDICINE HAT:

The Medicine Hat General Hospital Alumnae Association, for the first time, is offering a scholarship of one hundred dollars to a member of the graduating class wishing to take teaching and supervision. One hundred dollars is also being contributed towards the purchase of a Chase doll for the classroom.

VEGREVILLE:

Plans for the new wing to the nurses' home at the General Hospital are now complete. The addition includes a residence for the graduate staff, a large recreation room for the students, and a basement that will be fitted up for games. At a meeting of the alumnae association Kathleen Woolley accepted the responsibility for collecting donations to the Waf Memorial Trust Fund. A decision was made to send a dozen pair of stockings to the British Rest-Break Homes.

Miss Woolley, who recently completed a post-graduate course at St. Paul's Hospital, Vancouver, sponsored by the Queen Elizabeth Guild, has joined the staff. One of the Alberta University graduates, who is taking her degree in nursing, spent Easter Week at the school of nursing, taking her field work in teaching and supervision. Mrs. D. (Batiuk) Marsh is expected home from New Zealand during the summer.

BRITISH COLUMBIA

VANCOUVER:

St. Paul's Hospital:

At the St. Paul's Hospital Alumnae Association meeting held on March 4 it was decided to donate twenty-five dollars to the Red Cross and the same amount to the Spastic Paralysis Society. A committee was formed to study the present constitution and submit for discussion any changes they feel advisable.

On April 12, the alumnae held a tea for the R.N.A.B.C. convention delegates. The alumnae's entertainment for the graduating class is to take the form of a hayride. The class consists of eighty-eight nurses, one sister, and nine technicians. Our best wishes go out to them for those days of stress—the exams!

MANITOBA

ST. BONIFACE:

Lillian Thomson presided at the annual

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THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

SCHOLARSHIPS FOR SEASON, 1947-48

The Committee of Management of The Association of Nurses of the Province of Quebec is pleased to announce that two scholarships will be awarded this year, covering $500 each, to English- and French-speaking members in good standing in the Association, wishing to follow post-graduate courses.

Application forms may be obtained at the office of the Association,

504 MEDICAL ARTS BLDG.,
1538 SHERBROOKE ST. W.,
MONTREAL 25,

and must be returned completed before *June 1, 1947*.

E. FRANCES UPTON, R.N.
SECRETARY-REGISTRAR

FOOD IN HEALTH AND DISEASE

By Katherine Mitchell. This well-proved textbook for nurses (fifteenth printing) consists of: Part I. Food and Nutrition; Part II. Diet in Disease; Part III. Laboratory Outlines; Part IV. Outline of the Course in Dietetics. Contains the latest material on vitamins. 528 pages. 50 illustrations. $4.00.

PRINCIPLES OF PEDIATRICS AND PEDIATRIC NURSING

By Cecilia M. Knox. This book is concerned with the child in *both* health and disease, with *total* behaviour and development; physical, mental, social, emotional. 63 illustrations. 527 pages. 1945. $4.00.

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THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

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Registered Nurses without public health preparation will be considered for temporary employment.

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Apply to:

Miss Elizabeth Smellie
Chief Superintendent
114 Wellington Street
Ottawa.

meeting of St. Boniface Hospital Alumnae Association, following an enjoyable dinner as guests of the Canada Packers' Staff House. T. Greville and F. Connolly told of the chemical and nutritional progress being made at the plant. The newly-elected president is Mary Wilson with M. MacKenzie and T. Greville serving as vice-presidents. The secretaries are F. Avery and J. Baizley with Mrs. A. Willows acting as treasurer. A contribution of fifty dollars was made by the alumnae to the War Memorial Trust Fund.

Jean Lylyk is taking a six-month post-graduate course at St. Michael's Hospital, Toronto. Miss Sykes, oldest living graduate of the school of nursing, is a resident at Hospice Tache.

NEW BRUNSWICK

SAINT JOHN:

Mary Downing presided at a recent meeting of Saint John Chapter, N.B.A.R.N., when the business discussion included highlights from the executive meeting of the N.B.A.R.N., given by Margaret Murdoch. Refreshments were served by the Provincial Hospital staff nurses, where the members gathered.

At the beginning of March, a meeting of the Public Health Section, Saint John Chapter, took the form of a tea in honor of Muriel Sadlier who has retired from the staff of the Child Welfare. Guests included former associates of Miss Sadlier. Mrs. Warenford, on behalf of those present, made her a gift of a leather bag. Eleven members attended the business meeting held later, with Muriel Clarke presiding.

Jean Thomson is now on the Child Welfare staff.

ONTARIO

DISTRICT 1

Priscilla Campbell, president of the Ontario Hospital Association and administrator of the Public General Hospital, Chatham, was the guest speaker at a banquet held by the nurses of Sarnia and district. Graduates from thirty-four training schools, from Prince Edward Island to British Columbia, were present.

Mrs. Stronach's home was the scene of a successful tea and home-baking sale which was held to raise funds for the newly-formed registry.

DISTRICT 4

Anna Oram was elected chairman of District 4, R.N.A.O., at their annual meeting held at the Hamilton General Hospital. The vice-chairmen are Helene Snedden and Irene Mayali. Irene Lawson is serving as secretary-treasurer.

The most interesting feature of the meeting was the presentation of the Nurse Practice Act by Mary Millman, convener of the Legislation Committee, R.N.A.O. Many points concerning this act were clarified and there was considerable discussion.

District 6

Mrs. Machala, chairman, District 6, R.N.A.O., presided at a special meeting when Mary Millman spoke on the Nurse Practice Act for the information of the members. Miss Millman urged all nurses to discuss the draft and to come prepared to the R.N.A.O. annual meeting, ready to add or subtract from the act. Miss Thomson, from Peterborough, thanked the speaker for a most informative talk.

"Venereal Disease" was the subject of Dr. R. Anderson's address which was most enlightening. Dr. Anderson served with the R.C.A.F. in connection with this important work.

The meeting was well attended, including twenty-five nurses from Peterborough.

District 7

Brockville General Hospital:

The Brockville General Hospital Alumnae Association met recently to honor the retiring president, Mrs. Mae White, who has completed twenty years' service in that office. She was presented with a corsage of roses, a bracelet and matching earrings, and honored with a life membership in the association. A buffet supper was served, followed by a sing-song.

Mrs. Wm. Cook was elected president at the recent installation of officers. Lucy Merkley and Helen Corbett will serve as vice-presidents with Mrs. H. L. Bishop as secretary. The treasurer is Mrs. H. Vandusen.

District 8

Ottawa Civic Hospital:

Approximately three hundred guests attended the bridge and raffle held by the Ottawa Civic Hospital Alumnae Association and convened by Mrs. E. Storr and her committee. The president, Pearle Farmer, welcomed the members and their friends. Following bridge, refreshments were served. Mrs. John Aylen, newly-appointed trustee, drew the prizes for the raffle in aid of the British Nurses Relief Fund and other charities. The winners were Mmes J. R. Delahaye, M. Greenway, and Miss Farmer. The door and bridge prizes were drawn by Edith Young, director of nursing, the winners of the door prizes being Verna Nichols and Mrs. S. Cluff.

SASKATCHEWAN

Estevan:

The Estevan Chapter has made donations to the St. John Ambulance and Red Cross drives and also gave a rocking chair to Miss Ruple, a young disabled girl.

Maple Creek:

The Maple Creek Chapter recently sponsored a tea and a draw for an occasional chair. The money is to be used for parcels for

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What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

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needy nurses and to buy comforts for the nurses' rooms.

MOOSE JAW:

General Hospital:

Recent appointments include: E. Boychuk and E. Dayman to the operating-room; M. Towriss and M. Forge to the maternity wing. J. French has left the O.R. staff.

Providence Hospital:

The nurses' residence was the scene of a St. Patrick's Day party when the members of the nursing staff were hostesses to their friends. The social convener was M. Jamieson who arranged games, dancing, and a community sing-song. The student nurses served refreshments and the senior hostesses were Mmes H. C. Taylor, W. Oliver, D. Copeland, and E. May.

PRINCE ALBERT:

Miss Meyers, child welfare nurse, gave an interesting talk to the Prince Albert Chapter members at a recent meeting. To date 150 children have benefitted from the cod liver oil drive sponsored by this chapter.

Carol Sellhorn is now on the V.O.N. staff in Prince Albert. Recent appointments to the Victoria Hospital include Mmes Margaret Keith and Frances Horner. Mrs. Muriel Connel is leaving the sanatorium staff to reside in Regina.

REGINA:

K. W. Ellis, registrar, S.R.N.A., recently addressed the Regina Chapter, when she presented and discussed various problems of the nursing profession. Miss Ellis made known the appeal for funds to make it possible for a Holland representative to attend the I.C.N. Congress.

The Regina and Moose Jaw Chapters will be co-hostesses at the provincial convention to be held on May 29 and 30 in Regina. The V.O.N. is planning an intensive publicity campaign in connection with this meeting.

M. Larson has been appointed social worker with the Cancer Clinic.

General Hospital:

Thirty-five dollars was netted from the bridge tournament held by the Regina General Hospital Alumnae Association. J. Layng and M. Parker are on the operating-room staff.

Grey Nuns' Hospital:

The Lady Patronesses recently held a St. Patrick's Day dance for the student nurses.

Recent staff appointments include: A. Borys, H. Hoyer, D. Miller, and R. Reeves as head nurses; Mrs. B. (Keston) Kliman, station nurse, 2nd floor; Mrs. G. (Quellette) Hebert, station nurse, 3rd floor. Mrs. M. Fraser has resigned from the case room.

SWIFT CURRENT:

At a meeting of Swift Current Chapter the members voted to provide bedside tables for the children's ward of the General Hospital.

YORKTON:

Fifty-two nurses attended the annual banquet held by Yorkton Chapter. Mrs. S. McRae and K. Francis were appointed representatives to attend the National Film Board committee meeting to discuss the possibility of establishing a film council in Yorkton.

Positions Vacant

Superintendent for 64-bed non-sectarian hospital. Furnished apartment and full maintenance. Apply, giving references and stating salary expected, to Secretary, Board of Directors, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Instructress of Nurses immediately for small Training School. Private room and full maintenance. Apply, stating salary expected and giving references, to Secretary, Board of Directors, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Registered Nurse as **Assistant Instructor** and **Assistant Director of the School of Nursing** at Aberdeen Hospital, New Glasgow, Nova Scotia. Apply, stating qualifications, experience, age, salary expected, to Director of School of Nursing.

Science Instructor for School of Nursing; 200-bed hospital. Student enrolment of 62. One class yearly. Apply, stating qualifications, salary expected, and date available, to Director of Nursing, General Hospital, Belleville, Ont.

Clinical Supervisor urgently for 150-bed hospital, which is in process of being enlarged by a new wing to make it 250 beds. At present, 40 students in Training School. Apply, stating qualifications, experience, and salary required, to Supt., General Hospital, Port Arthur, Ont.

Obstetrical Supervisor for Royal Columbian Hospital, New Westminster, B.C. State qualifications, experience, and date of graduation in first letter. Apply to Supt.

Graduate Nurse, with **Public Health** certificate, for Nursing Service in Secondary Schools, Apply, stating qualifications, experience, age, and other particulars, to Miss Mollie Towers. Sec., Board of Education, Sault Ste. Marie, Ont.

Public Health Nurses for Bruce County Health Unit. Minimum salary: $1,600 with provision for yearly increases. Vacations with pay and sick leave allowance. Mileage allowance or car supplied, as desired. Apply to Dr. Wm. Fowler, Director, or Miss Florence Greenaway, Supervising Nurse, Bruce County Health Unit, Walkerton, Ont.

Graduate Nurses immediately for completely modern hospital. All-graduate staff. Commencing salary: $125 per month plus board, residence and laundry. 8-hour day with 1 day off per week. A month's vacation with pay after a year's service. Fare allowance not exceeding $60 refunded at end of 12 months. Apply, stating experience, to Matron, General Hospital, Prince Rupert, B.C.

Registered Nurses for **General Duty** prior to opening of new building, increasing capacity to 530 beds for Chronic Diseases. Hospital is nicely situated in residential Parkdale, close to lake and car service (15 minutes to Yonge St.). 8-hour day and 6-day week. 3 weeks' yearly vacation. 2 weeks' sick leave. Initial salary: $140 per month and laundry. $30 deducted if living in our exceptionally fine residence, or $10 for 2 meals if rooming out. Night duty initial salary: $145. Increases according to nurse's demonstrated ability. Senior positions available when new building opens. Apply to Supt., Queen Elizabeth Hospital, 130 Dunn Ave., Toronto 3, Ont.

General Duty Nurses for Norfolk General Hospital, Simcoe, Ontario. Salary: $110 per month (including pay for O.R. call) plus maintenance. Increase at end of 6 months, $115; at end of 1 year, $120. 8-hour day and 6-day week. Holidays with pay, sick leave and hospitalization. Additional $5.00 per month paid for 3:30 shift. Apply to Supt.

University of Alberta Hospital requires: **Supervisor of Instruction** to take charge of Teaching Program in undergraduate diploma and degree courses and to assist with post-graduate courses in nursing offered at the University. New appointment. **Operating-Room Teaching Supervisor** qualified to organize and carry out a teaching program in operating suite (4 major operating-rooms, 1 minor, 1 dental, 1 cystoscopic). New appointment. **Instructor in Principles and Practice of Nursing** to teach and supervise the nursing arts. **Science Instructor** to teach the basic sciences in undergraduate course. Teaching dept. to be housed in up-to-date new nurses' residence. School connected with 650-bed University Hospital. Apply, stating qualifications, to Director, School of Nursing, University of Alberta, Edmonton.

Assistant Superintendent. State qualifications and salary expected. **General Duty Nurses.** 6-day week. Hospitalization Plan. Salary: $100 per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

Nursing Arts Instructress for 135-bed hospital in Eastern Ontario. Student enrolment of 68; only one class admitted each year. Apply to Principal, School of Nursing, Civic Hospital, Peterborough, Ont.

Nursing Arts Instructor. Also **Ward Supervisor** for Medical and Surgical Unit. 100-bed General Hospital in Western Ontario. Apply, stating qualifications, experience, salary expected and date of availability, to Administrator, General Hospital, Woodstock, Ont.

Classroom Instructress for 100-bed hospital. Apply, stating qualifications and when services available, to Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, P.Q.

Operating-Room Nurses, Obstetrical Supervisors and **Night Supervisors** with knowledge of Obstetrics. Full maintenance; good living conditions. 470-bed hospital. Apply to Supt. of Nurses, General Hospital, Saint John, N.B.

Registered, Graduate Nurses for **General Duty** at once in a modern 35-bed Municipal Hospital in a thriving community. Salary: $100 per month with full maintenance. 8-hour day and 6-day week. 3 weeks' holiday with pay and raise in salary after a year of service. For further particulars apply to Matron, Municipal Hospital, Taber, Alta.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $140 per month living out, with annual increases up to $160 in 4 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Graduate Nurse, with Public Health training and experience, for **Social Service Dept.,** Toronto General Hospital. Apply, stating qualifications and experience, to Miss I. F. Deeth, Director, Social Service Dept., General Hospital, Toronto 5, Ont.

Floor Duty Nurse. 6-day week. Salary: $100 per month; full maintenance and free hospitalization. **Operating Room Nurse.** Apply, with references, to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Assistant Dietitian. Housekeeper. Home-Sister. Apply, stating qualifications, salary expected, and when available, to Matron, King Edward VII Memorial Hospital, Bermuda.

Two Graduate Nurses, with appropriate one-year University course, for following positions: (1) **Charge of Clinical Teaching** and **Assistant to Head Instructor.** (2) **Obstetrical Supervisor.** Small hospital. Full maintenance provided. For full particulars apply to Sister Supt., St. Vincent de Paul Hospital, Brockville, Ont.

Charge Nurse, Operating-Room, in 60-bed hospital. Salary: $115 per month with full maintenance. **Assistant Operating-Room Nurse.** Salary: $105 per month with full maintenance. Duties of both to commence July 15. Apply, stating qualifications and experience, to Supt., Great War Memorial Hospital, Perth, Ont.

Nurses, with **Public Health** training, for staff positions with the Toronto Branch, Victorian Order of Nurses. Minimum salary: $2,087 per annum. Initial uniform allowance: $75. Sick leave; annual vacation with pay provided after 12 months' service. Apply to Miss Ethel Cryderman, District Supt., Victorian Order of Nurses, 281 Sherbourne St., Toronto 2, Ont.

General Duty Nurses for 20-bed fully modern hospital. Salary: $120 per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

General Duty Staff Nurses for 60-bed modern hospital with 9 doctors on Medical Staff. Located in parkland area of sunny Central Alberta and adjacent to popular summer resort. 8-hour day and 6-day week. 3 weeks' annual vacation with pay at end of a year. Commencing salary: $110 monthly with maintenance; increased to $115 after 6 months and to $120 after 12 months' service. Apply, stating experience, age, and marital status, to Matron, Municipal Hospital, Red Deer, Alta.

Operating-Room Nurses for 200-bed hospital. Experience not necessary. 8-hour day and 5½ day week. 1 month vacation. Salary: $100 plus maintenance. For particulars apply to Miss Dora Parry, Supt. of Nurses, Children's Memorial Hospital, 1615 Cedar Ave., Montreal 25, P.Q.

Science Instructor. Assistant Superintendent of Nurses. Supervisor for Medical & Surgical Unit for Galt Hospital, Lethbridge, Alberta. 125 beds and Training School. New hospital in process. Apply, giving full particulars in first letter, to Supt. of Nurses.

Operating-Room Supervisor for June 1. Salary range: $125-$145, depending on qualifications and experience. **Operating-Room Nurse** with O.R. training for June 1. Salary range: $110-$135, depending on qualifications and experience. **General Duty Nurses.** Salary range: $100-$125. All salaries are plus board, room, and laundry. Apply to Supt., Trail-Tadanac Hospital, Trail, B.C.

Operating-Room Supervisor. 2 Operating-Room Scrub Nurses (special training preferred but experience will be considered). **Assistant Superintendent of Nurses. Instructor** (University post-graduate preferred). For active General Hospital in the Maritimes. Apply for full particulars, stating qualifications and salary expected, in care of Box 5, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Superintendent of Nurses. Instructress of Nurses (Science and Nursing Arts). **Dietitian.** For 120-bed hospital. Full particulars may be obtained by writing to Medical Supt., Victoria Hospital, Winnipeg, Man.

Graduate Nurses (2) for **General Duty** in small modern hospital in Peace River country. Salary: $120 for first 6 months and increased to $125 thereafter. 48-hour week. Full maintenance, including laundry. Refund of transportation from Edmonton will be made after 6 months in our employ. Write or wire at our expense to Municipal Hospital, Berwyn, Alta.

Registered Nurse or **Registered Medical Technologist** for **Dept. of Parenteral Therapy** at Belleville General Hospital. This position has definite possibilities favorable to applicant. For detailed information write or wire collect to Dr. J. B. McKay, Director, Branch Laboratory, General Hospital, Belleville, Ont.

Registered Nurses for **Head Nurses** and **General Duty** at Royal Columbian Hospital, New Westminster, B.C. State in first letter date of graduation and experience. Apply to Supt. of Nurses.

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Apply, stating qualifications and experience, to:

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With experience in Mental Hospital executive work. **Salary:** $160 per month plus full maintenance. Responsibilities include the charge of Female Nursing Service, Nurses' Training School, and housekeeping department.

Apply to:

Dr. Murray MacKay, Medical Superintendent, Nova Scotia Hospital, Dartmouth, N.S.

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Dr. Murray MacKay, Medical Superintendent, Nova Scotia Hospital, Dartmouth, N.S.

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1411 Crescent St., Montreal 25, P.Q.

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Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont.
Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

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Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

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Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlottetown.
Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25.
Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.